

**FY 2023 NEW YORK STATE EXECUTIVE BUDGET**

**HEALTH AND MENTAL HYGIENE  
ARTICLE VII LEGISLATION**

**FY 2023 NEW YORK STATE EXECUTIVE BUDGET**

**HEALTH AND MENTAL HYGIENE  
ARTICLE VII LEGISLATION**

**CONTENTS**

<b>PART</b>	<b>DESCRIPTION</b>	<b>STARTING PAGE NUMBER</b>
A	Nurses Across New York (NANY)	9
B	Interstate Medical Licensure Compact	11
C	Scope of Practice	64
D	Healthcare Workforce Bonuses	72
E	General Public Health Work County Support	81
F	Modernize Emergency Medical Services	84
G	Transfer of Oversight for Licensed Healthcare Professions	90
H	Medicaid Global Cap Metric Modification and Extension	94
I	Increase Medicaid trend factor by one percent to recognize provider labor cost increases	95
J	Hospital Related Recommendations	96
K	Statewide Health Care Facility Transformation Program IV	97
L	Notices for Changes in Ownership of Licensed Entities	101
M	Nursing Home Reforms	116
N	Promote Health Equity and Continuity of Coverage for Vulnerable Seniors and Individuals with Disabilities	120
O	Medicaid Long Term Care Program Reforms	141
P	Managed Care Reforms	150
Q	Essential Plan Reforms	174

<b>PART</b>	<b>DESCRIPTION</b>	<b>STARTING PAGE NUMBER</b>
R	Protect Reproductive Access for All	182
S	Maternal Health Reforms	185
T	Third Trimester Syphilis Screenings	188
U	Child Health Plus Reforms	188
V	Establish Telehealth Reimbursement Parity	192
W	Eliminate Unnecessary Requirements from the Utilization Threshold (UT) Program	196
X	Rename the Office of Minority Health	202
Y	Marriage Certificates	208
Z	This bill restructures and extends the Physicians Excess Medical Malpractice program	209
AA	Clarifying provisions regarding emergency medical services and surprise bills	231
BB	Pharmaceutical Related Recommendations	255
CC	Extend various provisions of the Public Health and Social Services Laws	255
DD	Human Services Cost-of-Living Adjustment	263
EE	988 Crisis Prevention and Behavioral Health Crisis Act	268
FF	Require reinvestment of underspending from behavioral health transition to Managed Care back into behavioral health services	273
GG	Extend Delivery System Reform Incentive Payment Practices	275
HH	Expand Access to Naloxone and Buprenorphine in Pharmacies	276
II	Establish Certification for Recovery Residences	277
JJ	Modernize and expand alcohol awareness program	279
KK	OASAS Capital Program Reforms	280

<b>PART</b>	<b>DESCRIPTION</b>	<b>STARTING PAGE NUMBER</b>
LL	Ambulatory Patient Group (APG) Rate Methodology Extension	282
MM	Extend Kendra's Law	290
NN	Expand the Property Pass through laws which affect individuals with mental illness living in community based residential programs	292
OO	Permanent authority for OMH and OPWDD to appoint temporary operators	293

Legislative Bill Drafting Commission  
12671-01-2

S. -----  
Senate  
-----

IN SENATE--Introduced by Sen

--read twice and ordered printed,  
and when printed to be committed  
to the Committee on

----- A.  
Assembly  
-----

IN ASSEMBLY--Introduced by M. of A.

with M. of A. as co-sponsors

--read once and referred to the  
Committee on

**\*BUDGBI\***

(Enacts into law major components of  
legislation necessary to implement  
the state health and mental hygiene  
budget for the 2022-2023 state  
fiscal year)

-----  
BUDGBI. HMH Governor

AN ACT

to amend the public health law, in  
relation to the implementation of  
the Nurses Across New York (NANY)  
program (Part A); to amend the  
education law, in relation to enact-  
ing the interstate medical licensure  
compact; and to amend the education  
law, in relation to enacting the  
nurse licensure compact (Part B); to  
amend the public health law and the  
education law, in relation to allow-

IN SENATE

Senate introducer's signature

The senators whose names are circled below wish to join me in the sponsorship  
of this proposal:

s15 Addabbo	s17 Felder	s07 Kaplan	s58 O'Mara	s10 Sanders
s52 Akshar	s59 Gallivan	s26 Kavanagh	s62 Ortt	s23 Savino
s36 Bailey	s05 Gaughran	s63 Kennedy	s01 Palumbo	s32 Sepulveda
s34 Biaggi	s12 Gianaris	s28 Krueger	s21 Parker	s41 Serino
s57 Borrello	s22 Gounardes	s24 Lanza	s19 Persaud	s29 Serrano
s04 Boyle	s47 Griffo	s11 Liu	s13 Ramos	s39 Skoufis
s44 Breslin	s40 Harckham	s50 Mannion	s61 Rath	s16 Stavisky
s25 Brisport	s54 Helming	s42 Martucci	s38 Reichlin-	s45 Stec
s08 Brooks	s46 Hinchey	s02 Mattera	Melnick	s35 Stewart-
s55 Brouk	s27 Hoylman	s53 May	s48 Ritchie	Cousins
s30 Cleare	s31 Jackson	s37 Mayer	s33 Rivera	s49 Tedisco
s14 Comrie	s43 Jordan	s20 Myrie	s60 Ryan	s06 Thomas
s56 Cooney	s09 Kaminsky	s51 Oberacker	s18 Salazar	s03 Weik

IN ASSEMBLY

Assembly introducer's signature

The Members of the Assembly whose names are circled below wish to join me in the  
multi-sponsorship of this proposal:

a049 Abbate	a045 Cymbrowitz	a100 Gunther	a015 Montesano	a076 Seawright	
a092 Abinanti	a018 Darling	a139 Hawley	a145 Morinello	a084 Septimo	
a031 Anderson	a053 Davila	a083 Heastie	a065 Niou	a016 Sillitti	
a122 Angelino	a003 DeStefano	a028 Hevesi	a037 Nolan	a052 Simon	
a107 Ashby	a070 Dickens	a128 Hunter	a144 Norris	a114 Simpson	
a035 Aubry	a054 Dilan	a029 Hyndman	a069 O'Donnell	a005 Smith	
a120 Barclay	a081 Dinowitz	a079 Jackson	a091 Otis	a118 Smullen	
a030 Barnwell	a147 DiPietro	a104 Jacobson	a132 Palmesano	a022 Solages	
a106 Barrett	a009 Durso	a011 Jean-Pierre	a088 Paulin	a110 Steck	
a082 Benedetto	a048 Eichenstein	a134 Jensen	a141 Peoples-	a010 Stern	
a042 Bichotte	a004 Englebright	a115 Jones	Stokes	a127 Stirpe	
	Hermelyn	a074 Epstein	a077 Joyner	a058 Perry	a102 Tague
a117 Blankenbush	a109 Fahy	a125 Kelles	a023 Pheffer	a064 Tannousis	
a098 Brabenc	a061 Fall	a040 Kim	Amato	a086 Tapia	
a026 Braunstein	a080 Fernandez	a105 Lalor	a089 Pretlow	a071 Taylor	
a138 Bronson	a008 Fitzpatrick	a013 Lavine	a073 Quart	a001 Thiele	
a012 Brown	a057 Forrest	a097 Lawler	a019 Ra	a033 Vanel	
a093 Burdick	a124 Friend	a126 Lemondes	a038 Rajkumar	a116 Walczyk	
a085 Burgos	a046 Frontus	a135 Lunsford	a006 Ramos	a055 Walker	
a142 Burke	a095 Galef	a123 Lupardo	a062 Reilly	a143 Wallace	
a119 Buttenschon	a050 Gallagher	a129 Magnarelli	a087 Reyes	a112 Walsh	
a094 Byrne	a131 Gallahan	a036 Mamdani	a043 Richardson	a041 Weinstein	
a133 Byrnes	a007 Gandolfo	a130 Manktelow	a078 Rivera, J.	a024 Weprin	
a103 Cahill	a002 Giglio, J.A.	a108 McDonald	a149 Rivera, J.D.	a059 Williams	
a044 Carroll	a148 Giglio, J.M.	a014 McDonough	a027 Rosenthal, D.	a113 Woerner	
a136 Clark	a066 Glick	a146 McMahan	a067 Rosenthal, L.	a096 Zebrowski	
a047 Colton	a034 Gonzalez-	a137 Meeks	a025 Rozic	a056 Zinerman	
a140 Conrad	Rojas	a017 Mikulin	a121 Salka	a060	
a032 Cook	a150 Goodell	a101 Miller, B.	a111 Santabarbara	a068	
a039 Cruz	a075 Gottfried	a020 Miller, M.	a090 Sayegh	a072	
a063 Cusick	a021 Griffin	a051 Mitaynes	a099 Schmitt		

1) Single House Bill (introduced and printed separately in either or  
both houses). Uni-Bill (introduced simultaneously in both houses and printed  
as one bill. Senate and Assembly introducer sign the same copy of the bill).

2) Circle names of co-sponsors and return to introduction clerk with 2  
signed copies of bill and: in Assembly 2 copies of memorandum in support, in  
Senate 4 copies of memorandum in support (single house); or 4 signed copies  
of bill and 6 copies of memorandum in support (uni-bill).

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

amend the public health law, in relation to the creation of a new statewide health care facility transformation program (Part K); to amend the public health law, in relation to streamlining and adding criteria to the certificate of need process (Part L); to amend the public health law, in relation to the definition of revenue in the minimum spending statute for nursing homes and the rates of payment and rates of reimbursement for residential health care facilities, and in relation to making a temporary payment to facilities in severe financial distress (Part M); to amend the social services law, in relation to Medicaid eligibility requirements for seniors and disabled individuals; and to repeal certain provisions of such law relating thereto (Part N); to amend the social services law, in relation to private duty nursing services reimbursement for nurses servicing adult members; to amend part MM of chapter 56 of the laws of 2020 directing the department of health to establish or procure the services of an independent panel of clinical professionals and to develop and implement a uniform task-based assessment tool, in relation to directing the department of health to develop guidelines and standards for the use of tasking tools; and to amend the public health law, in relation to establishing programs of all-inclusive care for the elderly (Part O); to amend the social services law and the public health law, in relation to providing authority for the department of health to competitively procure managed care organizations and requiring Medicaid managed care organizations, the essential plan and qualified health plans to contract with national cancer institute-designated cancer centers, where such centers agree to certain terms and conditions; and to repeal certain provisions of the social services law relating thereto (Part P); to amend the public health law

and the social services law, in relation to permitting the commissioner of health to submit a waiver that expands eligibility for New York's basic health program and increases the federal poverty limit cap for basic health program eligibility from two hundred to two hundred fifty percent; to amend the social services law, in relation to allowing pregnant individuals to be eligible for the basic health program and maintain coverage in the basic health program for one year post pregnancy and to deem a child born to an individual covered under the basic health program to be eligible for medical assistance; and providing for the repeal of certain provisions upon the expiration thereof (Part Q); to amend the insurance law, in relation to requiring private insurance plans to cover abortion services without cost-sharing (Part R); to amend the social services law, in relation to including expanded pre-natal and post-partum care as standard coverage when determined to be necessary and the continuance of eligibility for pregnant individuals to receive medical assistance in certain situations; and to repeal section 369-hh of the social services law (Part S); to amend the public health law, in relation to requiring third trimester syphilis testing (Part T); to amend the public health law, in relation to expanding benefits in the Child Health Plus Program, eliminating the premium contribution for certain households and transferring Child Health Plus rate setting authority from the Department of Financial Services to the Department of Health (Part U); to amend the public health law and the insurance law, in relation to reimbursement for commercial and Medicaid services provided via telehealth (Part V); to amend the social services law, in relation to eliminating unnecessary requirements from the utilization threshold program (Part W); to amend the public health law, in relation to redefining the duties and renam-



ing the office of minority health to the office of health equity and renaming the minority health council to the health equity council (Part X); to amend the domestic relations law, in relation to marriage certificates (Part Y); to amend chapter 266 of the laws of 1986 amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to the purchase of excess coverage by physicians and dentists and reimbursement of costs therefor, and to extending the physicians medical malpractice program; to amend part J of chapter 63 of the laws of 2001 amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, relating to the effectiveness of certain provisions of such chapter, in relation to extending certain provisions concerning the hospital excess liability pool; and to amend part H of chapter 57 of the laws of 2017, amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions relating thereto, in relation to extending provisions relating to excess coverage (Part Z); to amend the financial services law, the insurance law and the public health law, in relation to clarifying provisions regarding emergency medical services and surprise bills; and to repeal certain provisions of such law relating thereto (Subpart A); to amend the insurance law and the public health law, in relation to the federal no surprises act (Subpart B); and to amend the insurance law and the public health law, in relation to administrative simplification (Subpart C) (Part AA); to amend the public health law, in relation to prescriber prevails; and to repeal certain provisions of the social services law relating to coverage for certain prescription drugs (Part BB); to amend the social services law, the executive law and

the public health law, in relation to extending various provisions relating to health and mental hygiene; to amend chapter 58 of the laws of 2009, amending the public health law relating to payment by governmental agencies for general hospital inpatient services, in relation to the effectiveness thereof; to amend chapter 56 of the laws of 2013, amending the public health law relating to the general public health work program, in relation to the effectiveness thereof; to amend chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, in relation to the effectiveness thereof; to amend chapter 21 of the laws of 2011, amending the education law relating to authorizing pharmacists to perform collaborative drug therapy management with physicians in certain settings, in relation to the effectiveness thereof; to amend chapter 54 of the laws of 2016, amending part C of chapter 58 of the laws of 2005 relating to authorizing reimbursements for expenditures made by or on behalf of social services districts for medical assistance for needy persons and administration thereof, in relation to the effectiveness thereof; to amend chapter 56 of the laws of 2020, amending the tax law and the social services law relating to certain Medicaid management, in relation to the effectiveness thereof; to amend chapter 74 of the laws of 2020, relating to directing the department of health to convene a work group on rare diseases, in relation to the effectiveness thereof; and to amend chapter 414 of the laws of 2018, creating the radon task force, in relation to the effectiveness thereof (Part CC); in relation to establishing a cost of living adjustment for designated human services programs (Part DD); to amend the mental hygiene law, in relation to a 9-8-8 suicide prevention and behavioral health crisis hotline system (Part EE); to amend the social

services law, in relation to reinvesting savings recouped from behavioral health transition into managed care back into behavioral health services (Part FF); to amend chapter 57 of the laws of 2019 amending the public health law relating to waiver of certain regulations, in relation to the effectiveness thereof (Part GG); to amend the public health law, in relation to requiring a stock of opioid agonist medication for the treatment of an opioid use disorder (Part HH); to amend the mental hygiene law, in relation to community residences for addiction (Part II); to amend the mental hygiene law, in relation to expanding the scope of the alcohol awareness program to become the substance use awareness program (Part JJ); to amend the facilities development corporation act in relation to authorizing the facilities development corporation to acquire, improve and lease mental health facilities providing services for the treatment of addiction (Part KK); to amend chapter 56 of the laws of 2013 amending the public health law and other laws relating to general hospital reimbursement for annual rates, in relation to extending government rates for behavioral services and referencing the office of addiction services and supports; to amend part H of chapter 111 of the laws of 2010 relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, in relation to extending government rates for behavioral services referencing the office of addiction services and supports and in relation to the effectiveness thereof (Part LL); to amend Kendra's law, in relation to extending the expiration thereof; and to amend the mental hygiene law, in relation to extending Kendra's law and assisted outpatient treatment (Part MM); to amend the mental hygiene law, in relation to rental and mortgage

payments for the mentally ill (Part NN); and to amend part L of chapter 59 of the laws of 2016, amending the mental hygiene law relating to the appointment of temporary operators for the continued operation of programs and the provision of services for persons with serious mental illness and/or developmental disabilities and/or chemical dependence, in relation to the effectiveness thereof (Part OO)

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

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

12 PART A

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

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

17 § 2807-aa. Nurse loan repayment program. 1.(a) Monies shall be made  
18 available, subject to appropriations, for purposes of loan repayment in  
19 accordance with the provisions of this section for registered profes-  
20 sional nurses licensed to practice pursuant to section sixty-nine  
21 hundred five of the education law. Notwithstanding sections one hundred  
22 twelve and one hundred sixty-three of the state finance law and sections  
23 one hundred forty-two and one hundred forty-three of the economic devel-  
24 opment law, or any other contrary provision of law, such funding shall  
25 be allocated regionally with one-third of available funds going to New  
26 York city and two-thirds of available funds going to the rest of the

1 state and shall be distributed in a manner to be determined by the  
2 commissioner without a competitive bid or request for proposals.

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

11 (ii) Funding awarded pursuant to this section shall not exceed the  
12 total qualifying outstanding debt of the nurse from student loans to  
13 cover tuition and other related educational expenses, made by or guaran-  
14 teed by the federal or state government, or made by a lending or educa-  
15 tional institution approved under title IV of the federal higher educa-  
16 tion act. Loan repayment awards shall be used solely to repay such  
17 outstanding debt.

18 (iii) A nurse receiving funds pursuant to this section shall be eligi-  
19 ble for a loan repayment award to be determined by the commissioner over  
20 a three-year period distributed as follows: thirty percent of total  
21 award for the first year; thirty percent of total award for the second  
22 year; and any unpaid balance of the total award not to exceed the maxi-  
23 mum award amount for the third year.

24 (iv) In the event that a three-year commitment pursuant to the agree-  
25 ment referenced in subparagraph (i) of this paragraph is not fulfilled,  
26 the recipient shall be responsible for repayment of amounts paid which  
27 shall be calculated in accordance with the formula set forth in subdivi-

1 sion (b) of section two hundred fifty-four-o of title forty-two of the  
2 United States Code, as amended.

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

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

13 3. In the event there are undistributed funds within amounts made  
14 available for distributions pursuant to this section, such funds may be  
15 reallocated and distributed in current or subsequent distribution peri-  
16 ods in a manner determined by the commissioner for the purpose set forth  
17 in this section.

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

21 PART B

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

24 ARTICLE 169

25 INTERSTATE MEDICAL LICENSURE COMPACT

26 Section 8860. Short title.

- 1        8861. Purpose.
- 2        8862. Definitions.
- 3        8863. Eligibility.
- 4        8864. Designation of state of principal license.
- 5        8865. Application and issuance of expedited licensure.
- 6        8866. Fees for expedited licensure.
- 7        8867. Renewal and continued participation.
- 8        8868. Coordinated information system.
- 9        8869. Joint investigations.
- 10       8870. Disciplinary actions.
- 11       8871. Interstate medical licensure compact commission.
- 12       8872. Powers and duties of the interstate commission.
- 13       8873. Finance powers.
- 14       8874. Organization and operation of the interstate commission.
- 15       8875. Rulemaking functions of the interstate commission.
- 16       8876. Oversight of interstate compact.
- 17       8877. Enforcement of interstate compact.
- 18       8878. Default procedures.
- 19       8879. Dispute resolution.
- 20       8880. Member states, effective date and amendment.
- 21       8881. Withdrawal.
- 22       8882. Dissolution.
- 23       8883. Severability and construction.
- 24       8884. Binding effect of compact and other laws.
- 25       § 8860. Short title. This article shall be known and may be cited as
- 26 the "interstate medical licensure compact".
- 27       § 8861. Purpose. In order to strengthen access to health care, and in
- 28 recognition of the advances in the delivery of health care, the member



1 states of the interstate medical licensure compact have allied in common  
2 purpose to develop a comprehensive process that complements the existing  
3 licensing and regulatory authority of state medical boards, provides a  
4 streamlined process that allows physicians to become licensed in multi-  
5 ple states, thereby enhancing the portability of a medical license and  
6 ensuring the safety of patients. The compact creates another pathway  
7 for licensure and does not otherwise change a state's existing medical  
8 practice act. The compact also adopts the prevailing standard for licen-  
9 sure and affirms that the practice of medicine occurs where the patient  
10 is located at the time of the physician-patient encounter, and there-  
11 fore, requires the physician to be under the jurisdiction of the state  
12 medical board where the patient is located. State medical boards that  
13 participate in the compact retain the jurisdiction to impose an adverse  
14 action against a license to practice medicine in that state issued to a  
15 physician through the procedures in the compact.

16 § 8862. Definitions. In this compact:

17 1. "Bylaws" means those bylaws established by the interstate commis-  
18 sion pursuant to section eighty-eight hundred seventy-one of this arti-  
19 cle for its governance, or for directing and controlling its actions and  
20 conduct.

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

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

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

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

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

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

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

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

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

20 11. "Physician" means any person who:

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

25 (b) Passed each component of the United States Medical Licensing Exam-  
26 ination (USMLE) or the Comprehensive Osteopathic Medical Licensing Exam-  
27 ination (COMLEX-USA) within three attempts, or any of its predecessor

1 examinations accepted by a state medical board as an equivalent examina-  
2 tion for licensure purposes;

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

6 (d) Holds specialty certification or a time-unlimited specialty  
7 certificate recognized by the American Board of Medical Specialties or  
8 the American Osteopathic Association's Bureau of Osteopathic Special-  
9 ists;

10 (e) Possesses a full and unrestricted license to engage in the prac-  
11 tice of medicine issued by a member board;

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

15 (g) Has never held a license authorizing the practice of medicine  
16 subjected to discipline by a licensing agency in any state, federal, or  
17 foreign jurisdiction, excluding any action related to non-payment of  
18 fees related to a license;

19 (h) Has never had a controlled substance license or permit suspended  
20 or revoked by a state or the United States drug enforcement adminis-  
21 tration; and

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

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

26 13. "Rule" means a written statement by the interstate commission  
27 promulgated pursuant to section eighty-eight hundred seventy-two of this  
28 article that is of general applicability, implements, interprets, or

1 prescribes a policy or provision of the compact, or an organizational,  
2 procedural, or practice requirement of the interstate commission, and  
3 has the force and effect of statutory law in a member state, and  
4 includes the amendment, repeal, or suspension of an existing rule.

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

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

11 § 8863. Eligibility. 1. A physician must meet the eligibility require-  
12 ments as defined in subdivision eleven of section eighty-eight hundred  
13 sixty-two of this article to receive an expedited license under the  
14 terms and provisions of the compact.

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

20 § 8864. Designation of state of principal license. 1. A physician  
21 shall designate a member state as the state of principal license for  
22 purposes of registration for expedited licensure through the compact if  
23 the physician possesses a full and unrestricted license to practice  
24 medicine in that state, and the state is:

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

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

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

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

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

7 3. The interstate commission is authorized to develop rules to facili-  
8 tate redesignation of another member state as the state of principal  
9 license.

10 § 8865. Application and issuance of expedited licensure. 1. A physi-  
11 cian seeking licensure through the compact shall file an application for  
12 an expedited license with the member board of the state selected by the  
13 physician as the state of principal license.

14 2. Upon receipt of an application for an expedited license, the member  
15 board within the state selected as the state of principal license shall  
16 evaluate whether the physician is eligible for expedited licensure and  
17 issue a letter of qualification, verifying or denying the physician's  
18 eligibility, to the interstate commission.

19 (a) Static qualifications, which include verification of medical  
20 education, graduate medical education, results of any medical or licens-  
21 ing examination, and other qualifications as determined by the inter-  
22 state commission through rule, shall not be subject to additional prima-  
23 ry source verification where already primary source verified by the  
24 state of principal license.

25 (b) The member board within the state selected as the state of princi-  
26 pal license shall, in the course of verifying eligibility, perform a  
27 criminal background check of an applicant, including the use of the  
28 results of fingerprint or other biometric data checks compliant with the

1 requirements of the Federal Bureau of Investigation, with the exception  
2 of federal employees who have suitability determination in accordance  
3 with U.S. C.F.R. § 731.202.

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

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

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

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

22 6. An expedited license obtained through the compact shall be termi-  
23 nated if a physician fails to maintain a license in the state of princi-  
24 pal licensure for a non-disciplinary reason, without redesignation of a  
25 new state of principal licensure.

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

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

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

6 § 8867. Renewal and continued participation. 1. A physician seeking to  
7 renew an expedited license granted in a member state shall complete a  
8 renewal process with the interstate commission if the physician:

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

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

14 (c) Has not had a license authorizing the practice of medicine subject  
15 to discipline by a licensing agency in any state, federal, or foreign  
16 jurisdiction, excluding any action related to non-payment of fees  
17 related to a license; and

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

20 2. Physicians shall comply with all continuing professional develop-  
21 ment or continuing medical education requirements for renewal of a  
22 license issued by a member state.

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

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

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

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

5 § 8868. Coordinated information system. 1. The interstate commission  
6 shall establish a database of all physicians licensed, or who have  
7 applied for licensure, under section eighty-eight hundred sixty-five of  
8 this article.

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

13 3. Member boards shall report disciplinary or investigatory informa-  
14 tion determined as necessary and proper by rule of the interstate  
15 commission.

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

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

21 6. All information provided to the interstate commission or distrib-  
22 uted by member boards shall be confidential, filed under seal, and used  
23 only for investigatory or disciplinary matters.

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

26 § 8869. Joint investigations. 1. Licensure and disciplinary records of  
27 physicians are deemed investigative.



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

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

7 4. Member boards may share any investigative, litigation, or compli-  
8 ance materials in furtherance of any joint or individual investigation  
9 initiated under the compact.

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

13 § 8870. Disciplinary actions. 1. Any disciplinary action taken by any  
14 member board against a physician licensed through the compact shall be  
15 deemed unprofessional conduct which may be subject to discipline by  
16 other member boards, in addition to any violation of the medical prac-  
17 tice act or regulations in that state.

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

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

4 (a) impose the same or lesser sanction or sanctions against the physi-  
5 cian so long as such sanctions are consistent with the medical practice  
6 act of that state; or

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

10 4. If a license granted to a physician by a member board is revoked,  
11 surrendered, or relinquished in lieu of discipline, or suspended, then  
12 any license or licenses issued to the physician by any other member  
13 board or boards shall be suspended, automatically and immediately with-  
14 out further action necessary by the other member board or boards, for  
15 ninety days upon entry of the order by the disciplining board, to permit  
16 the member board or boards to investigate the basis for the action under  
17 the medical practice act of that state. A member board may terminate the  
18 automatic suspension of the license it issued prior to the completion of  
19 the ninety day suspension period in a manner consistent with the medical  
20 practice act of that state.

21 § 8871. Interstate medical licensure compact commission. 1. The member  
22 states hereby create the "interstate medical licensure compact commis-  
23 sion".

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

27 3. The interstate commission shall be a body corporate and joint agen-  
28 cy of the member states and shall have all the responsibilities, powers,

1 and duties set forth in the compact, and such additional powers as may  
2 be conferred upon it by a subsequent concurrent action of the respective  
3 legislatures of the member states in accordance with the terms of the  
4 compact.

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

12 (a) Allopathic or osteopathic physician appointed to a member board;  
13 (b) Executive director, executive secretary, or similar executive of a  
14 member board; or  
15 (c) Member of the public appointed to a member board.

16 5. The interstate commission shall meet at least once each calendar  
17 year. A portion of this meeting shall be a business meeting to address  
18 such matters as may properly come before the commission, including the  
19 election of officers. The chairperson may call additional meetings and  
20 shall call for a meeting upon the request of a majority of the member  
21 states.

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

24 7. Each commissioner participating at a meeting of the interstate  
25 commission is entitled to one vote. A majority of commissioners shall  
26 constitute a quorum for the transaction of business, unless a larger  
27 quorum is required by the bylaws of the interstate commission. A commis-  
28 sioner shall not delegate a vote to another commissioner. In the absence

1 of its commissioner, a member state may delegate voting authority for a  
2 specified meeting to another person from that state who shall meet the  
3 requirements of subdivision four of this section.

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

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

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

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

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

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

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

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

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

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

4 11. The interstate commission shall establish an executive committee,  
5 which shall include officers, members, and others as determined by the  
6 bylaws. The executive committee shall have the power to act on behalf of  
7 the interstate commission, with the exception of rulemaking, during  
8 periods when the interstate commission is not in session. When acting on  
9 behalf of the interstate commission, the executive committee shall over-  
10 see the administration of the compact including enforcement and compli-  
11 ance with the provisions of the compact, its bylaws and rules, and other  
12 such duties as necessary.

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

15 § 8872. Powers and duties of the interstate commission. The interstate  
16 commission shall have the duty and power to:

17 1. Oversee and maintain the administration of the compact;

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

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

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

26 5. Establish and appoint committees including, but not limited to, an  
27 executive committee as required by section eighty-eight hundred seven-

1 ty-one of this article, which shall have the power to act on behalf of  
2 the interstate commission in carrying out its powers and duties;

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

6 7. Establish and maintain one or more offices;

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

8 9. Purchase and maintain insurance and bonds;

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

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

14 12. Accept donations and grants of money, equipment, supplies, materi-  
15 als and services, and to receive, utilize, and dispose of it in a manner  
16 consistent with the conflict of interest policies established by the  
17 interstate commission;

18 13. Lease, purchase, accept contributions or donations of, or other-  
19 wise to own, hold, improve, or use, any property, real, personal, or  
20 mixed;

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

23 15. Establish a budget and make expenditures;

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

26 17. Report annually to the legislatures and governors of the member  
27 states concerning the activities of the interstate commission during the  
28 preceding year. Such reports shall also include reports of financial

1 audits and any recommendations that may have been adopted by the inter-  
2 state commission;

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

5 19. Maintain records in accordance with the bylaws;

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

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

9 § 8873. Finance powers. 1. The interstate commission may levy on and  
10 collect an annual assessment from each member state to cover the cost of  
11 the operations and activities of the interstate commission and its  
12 staff. The total assessment must be sufficient to cover the annual budg-  
13 et approved each year for which revenue is not provided by other sourc-  
14 es. The aggregate annual assessment amount shall be allocated upon a  
15 formula to be determined by the interstate commission, which shall  
16 promulgate a rule binding upon all member states.

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

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

21 4. The interstate commission shall be subject to a yearly financial  
22 audit conducted by a certified or licensed public accountant and the  
23 report of the audit shall be included in the annual report of the inter-  
24 state commission.

25 § 8874. Organization and operation of the interstate commission. 1.  
26 The interstate commission shall, by a majority of commissioners present  
27 and voting, adopt bylaws to govern its conduct as may be necessary or

1 appropriate to carry out the purposes of the compact within twelve  
2 months of the first interstate commission meeting.

3 2. The interstate commission shall elect or appoint annually from  
4 among its commissioners a chairperson, a vice-chairperson, and a treas-  
5 urer, each of whom shall have such authority and duties as may be speci-  
6 fied in the bylaws. The chairperson, or in the chairperson's absence or  
7 disability, the vice-chairperson, shall preside at all meetings of the  
8 interstate commission.

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

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

21 (a) The liability of the executive director and employees of the  
22 interstate commission or representatives of the interstate commission,  
23 acting within the scope of such person's employment or duties for acts,  
24 errors, or omissions occurring within such person's state, may not  
25 exceed the limits of liability set forth under the constitution and laws  
26 of that state for state officials, employees, and agents. The interstate  
27 commission is considered to be an instrumentality of the states for the  
28 purposes of any such action. Nothing in this paragraph shall be



1 construed to protect such person from suit or liability for damage,  
2 loss, injury, or liability caused by the intentional or willful and  
3 wanton misconduct of such person.

4 (b) The interstate commission shall defend the executive director, its  
5 employees, and subject to the approval of the attorney general or other  
6 appropriate legal counsel of the member state represented by an inter-  
7 state commission representative, shall defend such interstate commission  
8 representative in any civil action seeking to impose liability arising  
9 out of an actual or alleged act, error or omission that occurred within  
10 the scope of interstate commission employment, duties or responsibil-  
11 ities, or that the defendant had a reasonable basis for believing  
12 occurred within the scope of interstate commission employment, duties,  
13 or responsibilities, provided that the actual or alleged act, error, or  
14 omission did not result from intentional or willful and wanton miscon-  
15 duct on the part of such person.

16 (c) To the extent not covered by the state involved, member state, or  
17 the interstate commission, the representatives or employees of the  
18 interstate commission shall be held harmless in the amount of a settle-  
19 ment or judgment, including attorney's fees and costs, obtained against  
20 such persons arising out of an actual or alleged act, error, or omission  
21 that occurred within the scope of interstate commission employment,  
22 duties, or responsibilities, or that such persons had a reasonable basis  
23 for believing occurred within the scope of interstate commission employ-  
24 ment, duties, or responsibilities, provided that the actual or alleged  
25 act, error, or omission did not result from intentional or willful and  
26 wanton misconduct on the part of such persons.

27 § 8875. Rulemaking functions of the interstate commission. 1. The  
28 interstate commission shall promulgate reasonable rules in order to

1 effectively and efficiently achieve the purposes of the compact.  
2 Notwithstanding the foregoing, in the event the interstate commission  
3 exercises its rulemaking authority in a manner that is beyond the scope  
4 of the purposes of the compact, or the powers granted hereunder, then  
5 such an action by the interstate commission shall be invalid and have no  
6 force or effect.

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

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

22 § 8876. Oversight of interstate compact. 1. The executive, legisla-  
23 tive, and judicial branches of state government in each member state  
24 shall enforce the compact and shall take all actions necessary and  
25 appropriate to effectuate the compact's purposes and intent. The  
26 provisions of the compact and the rules promulgated hereunder shall have  
27 standing as statutory law but shall not override existing state authori-  
28 ty to regulate the practice of medicine.

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

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

10 § 8877. Enforcement of interstate compact. 1. The interstate commis-  
11 sion, in the reasonable exercise of its discretion, shall enforce the  
12 provisions and rules of the compact.

13 2. The interstate commission may, by majority vote of the commission-  
14 ers, initiate legal action in the United States District Court for the  
15 District of Columbia, or, at the discretion of the interstate commis-  
16 sion, in the federal district where the interstate commission has its  
17 principal offices, to enforce compliance with the provisions of the  
18 compact, and its promulgated rules and bylaws, against a member state in  
19 default. The relief sought may include both injunctive relief and  
20 damages. In the event judicial enforcement is necessary, the prevailing  
21 party shall be awarded all costs of such litigation including reasonable  
22 attorney's fees.

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

27 § 8878. Default procedures. 1. The grounds for default include, but  
28 are not limited to, failure of a member state to perform such obli-

1 gations or responsibilities imposed upon it by the compact, or the rules  
2 and bylaws of the interstate commission promulgated under the compact.

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

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

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

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

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

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

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

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

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

15 § 8879. Dispute resolution. 1. The interstate commission shall  
16 attempt, upon the request of a member state, to resolve disputes which  
17 are subject to the compact and which may arise among member states or  
18 member boards.

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

21 § 8880. Member states, effective date and amendment. 1. Any state is  
22 eligible to become a member state of the compact.

23 2. The compact shall become effective and binding upon legislative  
24 enactment of the compact into law by no less than seven states. There-  
25 after, it shall become effective and binding on a state upon enactment  
26 of the compact into law by that state.

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

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

8     § 8881. Withdrawal. 1. Once effective, the compact shall continue in  
9 force and remain binding upon each and every member state; provided that  
10 a member state may withdraw from the compact by specifically repealing  
11 the statute which enacted the compact into law.

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

17     3. The withdrawing state shall immediately notify the chairperson of  
18 the interstate commission in writing upon the introduction of legis-  
19 lation repealing the compact in the withdrawing state.

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

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

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

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

8 § 8882. Dissolution. 1. The compact shall dissolve effective upon the  
9 date of the withdrawal or default of the member state which reduces the  
10 membership in the compact to one member state.

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

15 § 8883. Severability and construction. 1. The provisions of the  
16 compact shall be severable, and if any phrase, clause, sentence, or  
17 provision is deemed unenforceable, the remaining provisions of the  
18 compact shall be enforceable.

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

21 3. Nothing in the compact shall be construed to prohibit the applica-  
22 bility of other interstate compacts to which the states are members.

23 § 8884. Binding effect of compact and other laws. 1. Nothing contained  
24 in this article shall prevent the enforcement of any other law of a  
25 member state that is not inconsistent with the compact.

26 2. All laws in a member state in conflict with the compact are super-  
27 seded to the extent of the conflict.

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

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

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

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

13 ARTICLE 170

14 NURSE LICENSURE COMPACT

15 Section 8900. Nurse licensure compact.

16 8901. Findings and declaration of purpose.

17 8902. Definitions.

18 8903. General provisions and jurisdiction.

19 8904. Applications for licensure in a party state.

20 8905. Additional authorities invested in party state licensing  
21 boards.

22 8906. Coordinated licensure information system and exchange of  
23 information.

24 8907. Establishment of the interstate commission of nurse licen-  
25 sure compact administrators.

26 8908. Rulemaking.

27 8909. Oversight, dispute resolution and enforcement.

28 8910. Effective date, withdrawal and amendment.



1           8911. Construction and severability.

2       § 8900. Nurse licensure compact. The nurse license compact as set  
3 forth in the article is hereby adopted and entered into with all party  
4 states joining therein.

5       § 8901. Findings and declaration of purpose 1. Findings. The party  
6 states find that:

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

10       b. Violations of nurse licensure and other laws regulating the prac-  
11 tice of nursing may result in injury or harm to the public;

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

16       d. New practice modalities and technology make compliance with indi-  
17 vidual state nurse licensure laws difficult and complex;

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

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

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

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

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

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

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

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

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

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

13 § 8902. Definitions. 1. Definitions. As used in this compact:

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

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

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

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

3 e. "Current significant investigative information" means:

4 1. Investigative information that a licensing board, after a prelimi-  
5 nary inquiry that includes notification and an opportunity for the nurse  
6 to respond, if required by state law, has reason to believe is not  
7 groundless and, if proved true, would indicate more than a minor infrac-  
8 tion; or

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

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

17 f. "Encumbrance" means a revocation or suspension of, or any limita-  
18 tion on, the full and unrestricted practice of nursing imposed by a  
19 licensing board.

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

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

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

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

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

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

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

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

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

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

20 § 8903. General provisions and jurisdiction. 1. General provisions and  
21 jurisdiction. a. A multistate license to practice registered or licensed  
22 practical/vocational nursing issued by a home state to a resident in  
23 that state will be recognized by each party state as authorizing a nurse  
24 to practice as a registered nurse (RN) or as a licensed  
25 practical/vocational nurse (LPN/VN), under a multistate licensure privi-  
26 lege, in each party state.

27 b. A state shall implement procedures for considering the criminal  
28 history records of applicants for an initial multistate license or

1 licensure by endorsement. Such procedures shall include the submission  
2 of fingerprints or other biometric-based information by applicants for  
3 the purpose of obtaining an applicant's criminal history record informa-  
4 tion from the federal bureau of investigation and the agency responsible  
5 for retaining that state's criminal records.

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

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

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

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

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

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

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

25 vi. Has submitted, in connection with an application for initial  
26 licensure or licensure by endorsement, fingerprints or other biometric  
27 data for the purpose of obtaining criminal history record information

1 from the federal bureau of investigation and the agency responsible for  
2 retaining that state's criminal records;

3 vii. Has not been convicted or found guilty, or has entered into an  
4 agreed disposition, of a felony offense under applicable state or feder-  
5 al criminal law;

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

9 ix. Is not currently enrolled in an alternative program;

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

12 xi. Has a valid United States social security number.

13 d. All party states shall be authorized, in accordance with existing  
14 state due process law, to take adverse action against a nurse's multi-  
15 state licensure privilege such as revocation, suspension, probation or  
16 any other action that affects a nurse's authorization to practice under  
17 a multistate licensure privilege, including cease and desist actions. If  
18 a party state takes such action, it shall promptly notify the adminis-  
19 trator of the coordinated licensure information system. The administra-  
20 tor of the coordinated licensure information system shall promptly noti-  
21 fy the home state of any such actions by remote states.

22 e. A nurse practicing in a party state shall comply with the state  
23 practice laws of the state in which the client is located at the time  
24 service is provided. The practice of nursing is not limited to patient  
25 care but shall include all nursing practice as defined by the state  
26 practice laws of the party state in which the client is located. The  
27 practice of nursing in a party state under a multistate licensure privi-  
28 lege will subject a nurse to the jurisdiction of the licensing board,

1 the courts and the laws of the party state in which the client is  
2 located at the time service is provided.

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

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

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

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

23 § 8904. Applications for licensure in a party state. 1. Applications  
24 for licensure in a party state. a. Upon application for a multistate  
25 license, the licensing board in the issuing party state shall ascertain,  
26 through the coordinated licensure information system, whether the appli-  
27 cant has ever held, or is the holder of, a license issued by any other  
28 state, whether there are any encumbrances on any license or multistate

1 licensure privilege held by the applicant, whether any adverse action  
2 has been taken against any license or multistate licensure privilege  
3 held by the applicant and whether the applicant is currently participat-  
4 ing in an alternative program.

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

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

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

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

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

21 § 8905. Additional authorities invested in party state licensing  
22 boards. 1. Licensing board authority. In addition to the other powers  
23 conferred by state law, a licensing board shall have the authority to:

24 a. Take adverse action against a nurse's multistate licensure privi-  
25 lege to practice within that party state.

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



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

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

8 c. Complete any pending investigations of a nurse who changes primary  
9 state of residence during the course of such investigations. The licens-  
10 ing board shall also have the authority to take appropriate action or  
11 actions and shall promptly report the conclusions of such investigations  
12 to the administrator of the coordinated licensure information system.  
13 The administrator of the coordinated licensure information system shall  
14 promptly notify the new home state of any such actions.

15 d. Issue subpoenas for both hearings and investigations that require  
16 the attendance and testimony of witnesses, as well as the production of  
17 evidence. Subpoenas issued by a licensing board in a party state for the  
18 attendance and testimony of witnesses or the production of evidence from  
19 another party state shall be enforced in the latter state by any court  
20 of competent jurisdiction, according to the practice and procedure of  
21 that court applicable to subpoenas issued in proceedings pending before  
22 it. The issuing authority shall pay any witness fees, travel expenses,  
23 mileage and other fees required by the service statutes of the state in  
24 which the witnesses or evidence are located.

25 e. Obtain and submit, for each nurse licensure applicant, fingerprint  
26 or other biometric-based information to the federal bureau of investi-  
27 gation for criminal background checks, receive the results of the feder-

1 al bureau of investigation record search on criminal background checks  
2 and use the results in making licensure decisions.

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

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

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

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

22 § 8906. Coordinated licensure information system and exchange of  
23 information. 1. Coordinated licensure information system and exchange  
24 of information. a. All party states shall participate in a coordinated  
25 licensure information system of all licensed registered nurses (RNs) and  
26 licensed practical/vocational nurses (LPNs/VNs). This system will  
27 include information on the licensure and disciplinary history of each

1 nurse, as submitted by party states, to assist in the coordination of  
2 nurse licensure and enforcement efforts.

3 b. The commission, in consultation with the administrator of the coor-  
4 dated licensure information system, shall formulate necessary and  
5 proper procedures for the identification, collection and exchange of  
6 information under this compact.

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

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

17 e. Notwithstanding any other provision of law, all party state licens-  
18 ing boards contributing information to the coordinated licensure infor-  
19 mation system may designate information that may not be shared with  
20 non-party states or disclosed to other entities or individuals without  
21 the express permission of the contributing state.

22 f. Any personally identifiable information obtained from the coordi-  
23 nated licensure information system by a party state licensing board  
24 shall not be shared with non-party states or disclosed to other entities  
25 or individuals except to the extent permitted by the laws of the party  
26 state contributing the information.

27 g. Any information contributed to the coordinated licensure informa-  
28 tion system that is subsequently required to be expunged by the laws of

1 the party state contributing that information shall also be expunged  
2 from the coordinated licensure information system.

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

6 i. Identifying information;

7 ii. Licensure data;

8 iii. Information related to alternative program participation; and

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

11 i. The compact administrator of a party state shall provide all inves-  
12 tigative documents and information requested by another party state.

13 § 8907. Establishment of the interstate commission of nurse licensure  
14 compact administrators. 1. Commission of nurse licensure compact admin-  
15 istrators. The party states hereby create and establish a joint public  
16 entity known as the interstate commission of nurse licensure compact  
17 administrators. The commission is an instrumentality of the party  
18 states.

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

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

27 4. Membership, voting and meetings. a. Each party state shall have and  
28 be limited to one administrator. The head of the state licensing board

1 or designee shall be the administrator of this compact for each party  
2 state. Any administrator may be removed or suspended from office as  
3 provided by the law of the state from which the administrator is  
4 appointed. Any vacancy occurring in the commission shall be filled in  
5 accordance with the laws of the party state in which the vacancy exists.

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

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

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

18 5. Closed meetings. a. The commission may convene in a closed, nonpub-  
19 lic meeting if the commission shall discuss:

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

22 ii. The employment, compensation, discipline or other personnel  
23 matters, practices or procedures related to specific employees or other  
24 matters related to the commission's internal personnel practices and  
25 procedures;

26 iii. Current, threatened or reasonably anticipated litigation;

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

- 1 v. Accusing any person of a crime or formally censuring any person;  
2 vi. Disclosure of trade secrets or commercial or financial information  
3 that is privileged or confidential;  
4 vii. Disclosure of information of a personal nature where disclosure  
5 would constitute a clearly unwarranted invasion of personal privacy;  
6 viii. Disclosure of investigatory records compiled for law enforcement  
7 purposes;  
8 ix. Disclosure of information related to any reports prepared by or on  
9 behalf of the commission for the purpose of investigation of compliance  
10 with this compact; or  
11 x. Matters specifically exempted from disclosure by federal or state  
12 statute.
- 13 b. If a meeting, or portion of a meeting, is closed pursuant to this  
14 paragraph the commission's legal counsel or designee shall certify that  
15 the meeting may be closed and shall reference each relevant exempting  
16 provision. The commission shall keep minutes that fully and clearly  
17 describe all matters discussed in a meeting and shall provide a full and  
18 accurate summary of actions taken, and the reasons therefor, including a  
19 description of the views expressed. All documents considered in  
20 connection with an action shall be identified in such minutes. All  
21 minutes and documents of a closed meeting shall remain under seal,  
22 subject to release by a majority vote of the commission or order of a  
23 court of competent jurisdiction.
- 24 c. The commission shall, by a majority vote of the administrators,  
25 prescribe bylaws or rules to govern its conduct as may be necessary or  
26 appropriate to carry out the purposes and exercise the powers of this  
27 compact, including but not limited to:  
28 i. Establishing the fiscal year of the commission;

1 ii. Providing reasonable standards and procedures:

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

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

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

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

17 v. Providing reasonable standards and procedures for the establishment  
18 of the personnel policies and programs of the commission. Notwithstand-  
19 ing any civil service or other similar laws of any party state, the  
20 bylaws shall exclusively govern the personnel policies and programs of  
21 the commission; and

22 vi. Providing a mechanism for winding up the operations of the commis-  
23 sion and the equitable disposition of any surplus funds that may exist  
24 after the termination of this compact after the payment or reserving of  
25 all of its debts and obligations.

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

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

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

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

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

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

13 c. To purchase and maintain insurance and bonds;

14 d. To borrow, accept or contract for services of personnel, including,  
15 but not limited to, employees of a party state or nonprofit organiza-  
16 tions;

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

21 f. To hire employees, elect or appoint officers, fix compensation,  
22 define duties, grant such individuals appropriate authority to carry out  
23 the purposes of this compact, and to establish the commission's person-  
24 nel policies and programs relating to conflicts of interest, qualifica-  
25 tions of personnel and other related personnel matters;

26 g. To accept any and all appropriate donations, grants and gifts of  
27 money, equipment, supplies, materials and services, and to receive,



1 utilize and dispose of the same; provided that at all times the commis-  
2 sion shall avoid any appearance of impropriety or conflict of interest;

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

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

9 j. To establish a budget and make expenditures;

10 k. To borrow money;

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

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

17 n. To adopt and use an official seal; and

18 o. To perform such other functions as may be necessary or appropriate  
19 to achieve the purposes of this compact consistent with the state regu-  
20 lation of nurse licensure and practice.

21 8. Financing of the commission. a. The commission shall pay, or  
22 provide for the payment of, the reasonable expenses of its establish-  
23 ment, organization and ongoing activities.

24 b. The commission may also levy on and collect an annual assessment  
25 from each party state to cover the cost of its operations, activities  
26 and staff in its annual budget as approved each year. The aggregate  
27 annual assessment amount, if any, shall be allocated based upon a formu-

1 la to be determined by the commission, which shall promulgate a rule  
2 that is binding upon all party states.

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

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

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

26 b. The commission shall defend any administrator, officer, executive  
27 director, employee or representative of the commission in any civil  
28 action seeking to impose liability arising out of any actual or alleged

1 act, error or omission that occurred within the scope of the commis-  
2 sion's employment, duties or responsibilities, or that the person  
3 against whom the claim is made had a reasonable basis for believing  
4 occurred within the scope of the commission's employment, duties or  
5 responsibilities; provided that nothing herein shall be construed to  
6 prohibit that person from retaining his or her own counsel; and provided  
7 further that the actual or alleged act, error or omission did not result  
8 from that person's intentional, willful or wanton misconduct.

9 c. The commission shall indemnify and hold harmless any administrator,  
10 officer, executive director, employee or representative of the commis-  
11 sion for the amount of any settlement or judgment obtained against that  
12 person arising out of any actual or alleged act, error or omission that  
13 occurred within the scope of the commission's employment, duties or  
14 responsibilities, or that such person had a reasonable basis for believ-  
15 ing occurred within the scope of the commission's employment, duties or  
16 responsibilities, provided that the actual or alleged act, error or  
17 omission did not result from the intentional, willful or wanton miscon-  
18 duct of that person.

19 § 8908. Rulemaking. 1. Rulemaking. a. The commission shall exercise  
20 its rulemaking powers pursuant to the criteria set forth in this article  
21 and the rules adopted thereunder. Rules and amendments shall become  
22 binding as of the date specified in each rule or amendment and shall  
23 have the same force and effect as provisions of this compact.

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

26 2. Notice. a. Prior to promulgation and adoption of a final rule or  
27 rules by the commission, and at least sixty days in advance of the meet-

1 ing at which the rule will be considered and voted upon, the commission  
2 shall file a notice of proposed rulemaking:

3 i. On the website of the commission; and

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

6 b. The notice of proposed rulemaking shall include:

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

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

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

13 iv. The manner in which interested persons may submit notice to the  
14 commission of their intention to attend the public hearing and any writ-  
15 ten comments.

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

19 3. Public hearings on rules. a. The commission shall grant an opportu-  
20 nity for a public hearing before it adopts a rule or amendment.

21 b. The commission shall publish the place, time and date of the sched-  
22 uled public hearing.

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

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

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

6 d. Following the scheduled hearing date, or by the close of business  
7 on the scheduled hearing date if the hearing was not held, the commis-  
8 sion shall consider all written and oral comments received.

9 4. Voting on rules. The commission shall, by majority vote of all  
10 administrators, take final action on the proposed rule and shall deter-  
11 mine the effective date of the rule, if any, based on the rulemaking  
12 record and the full text of the rule.

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

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

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

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

25 6. Revisions. The commission may direct revisions to a previously  
26 adopted rule or amendment for purposes of correcting typographical  
27 errors, errors in format, errors in consistency or grammatical errors.  
28 Public notice of any revisions shall be posted on the website of the

1 commission. The revision shall be subject to challenge by any person for  
2 a period of thirty days after posting. The revision may be challenged  
3 only on grounds that the revision results in a material change to a  
4 rule. A challenge shall be made in writing, and delivered to the  
5 commission, prior to the end of the notice period. If no challenge is  
6 made, the revision will take effect without further action. If the  
7 revision is challenged, the revision may not take effect without the  
8 approval of the commission.

9 § 8909. Oversight, dispute resolution and enforcement. 1. Oversight.

10 a. Each party state shall enforce this compact and take all actions  
11 necessary and appropriate to effectuate this compact's purposes and  
12 intent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 § 8910. Effective date, withdrawal and amendment. 1. Effective date.  
26 a. This compact shall become effective and binding on the earlier of  
27 the date of legislative enactment of this compact into law by no less  
28 than twenty-six states or the effective date of the chapter of the laws



1 of two thousand twenty-two that enacted this compact. Thereafter, the  
2 compact shall become effective and binding as to any other compacting  
3 state upon enactment of the compact into law by that state. All party  
4 states to this compact, that also were parties to the prior nurse licen-  
5 sure compact, superseded by this compact, (herein referred to as "prior  
6 compact"), shall be deemed to have withdrawn from said prior compact  
7 within six months after the effective date of this compact.

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

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

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

20 c. Nothing contained in this compact shall be construed to invalidate  
21 or prevent any nurse licensure agreement or other cooperative arrange-  
22 ment between a party state and a non-party state that is made in accord-  
23 ance with the other provisions of this compact.

24 3. Amendment. a. This compact may be amended by the party states. No  
25 amendment to this compact shall become effective and binding upon the  
26 party states unless and until it is enacted into the laws of all party  
27 states.

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

4 § 8911. Construction and severability. 1. Construction and severabil-  
5 ity. This compact shall be liberally construed so as to effectuate the  
6 purposes thereof. The provisions of this compact shall be severable, and  
7 if any phrase, clause, sentence or provision of this compact is declared  
8 to be contrary to the constitution of any party state or of the United  
9 States, or if the applicability thereof to any government, agency,  
10 person or circumstance is held to be invalid, the validity of the  
11 remainder of this compact and the applicability thereof to any govern-  
12 ment, agency, person or circumstance shall not be affected thereby. If  
13 this compact shall be held to be contrary to the constitution of any  
14 party state, this compact shall remain in full force and effect as to  
15 the remaining party states and in full force and effect as to the party  
16 state affected as to all severable matters.

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

19 3. a. an applicant for licensure in a qualified high-need healthcare  
20 profession who provides documentation and attestation that he or she  
21 holds a license in good standing from another state, may request the  
22 issuance of a temporary practice permit, which, if granted will permit  
23 the applicant to work under the supervision of a New York state licensee  
24 in accordance with regulations of the commissioner. The department may  
25 grant such temporary practice permit when it appears based on the appli-  
26 cation and supporting documentation received that the applicant will  
27 meet the requirements for licensure in this state because he or she has  
28 provided documentation and attestation that they hold a license in good

1 standing from another state with significantly comparable licensure  
2 requirements to those of this state, except the department has not been  
3 able to secure direct source verification of the applicant's underlying  
4 credentials (e.g., license verification, receipt of original transcript,  
5 experience verification). Such permit shall be valid for six months or  
6 until ten days after notification that the applicant does not meet the  
7 qualifications for licensure. An additional six months may be granted  
8 upon a determination by the department that the applicant is expected to  
9 qualify for the full license upon receipt of the remaining direct source  
10 verification documents requested by the department in such time period  
11 and that the delay in providing the necessary documentation for full  
12 licensure was due to extenuating circumstances which the applicant could  
13 not avoid.

14 b. a temporary practice permit issued under paragraph a of this subdi-  
15 vision shall be subject to the full disciplinary and regulatory authori-  
16 ty of the board of regents and the department, pursuant to this title,  
17 as if such authorization were a professional license issued under this  
18 article.

19 c. for purposes of this subdivision "high-need healthcare profession"  
20 means a licensed healthcare profession of which there are an insuffi-  
21 cient number of licensees to serve in the state or a region of the  
22 state, as determined by the commissioner of health, in consultation with  
23 the commissioner of education. The commissioner of health shall main-  
24 tain a list of such licensed professions, which shall be posted online  
25 and updated from time to time as warranted.

26 § 4. This act shall take effect immediately and shall be deemed to  
27 have been in full force and effect on and after April 1, 2022; provided,  
28 however, section three of this act shall take effect on the ninetieth

1 day after it shall have become a law. Effective immediately, the addi-  
2 tion, amendment and/or repeal of any rule or regulation necessary for  
3 the implementation of this act on its effective date are authorized to  
4 be made and completed on or before such effective date.

5 PART C

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

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

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

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

24 § 3. Subparagraph (iv) of paragraph (a) of subdivision 3 of section  
25 6902 of the education law, as amended by section 2 of part D of chapter  
26 56 of the laws of 2014, is amended to read as follows:

1 (iv) The practice protocol shall reflect current accepted medical and  
2 nursing practice[. The protocols shall be filed with the department  
3 within ninety days of the commencement of the practice] and may be  
4 updated periodically. The commissioner shall make regulations establish-  
5 ing the procedure for the review of protocols and the disposition of any  
6 issues arising from such review.

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

10 (b) Notwithstanding subparagraph (i) of paragraph (a) of this subdivi-  
11 sion[,]:

12 (i) a nurse practitioner, certified under section sixty-nine hundred  
13 ten of this article and practicing for more than three thousand six  
14 hundred hours in a specialty area other than primary care or such other  
15 related areas as determined by the commissioner of health, may comply  
16 with this paragraph in lieu of complying with the requirements of para-  
17 graph (a) of this subdivision relating to collaboration with a physi-  
18 cian, a written practice agreement and written practice protocols. A  
19 nurse practitioner complying with this paragraph shall have collabora-  
20 tive relationships with one or more licensed physicians qualified to  
21 collaborate in the specialty involved or a hospital, licensed under  
22 article twenty-eight of the public health law, that provides services  
23 through licensed physicians qualified to collaborate in the specialty  
24 involved and having privileges at such institution. As evidence that the  
25 nurse practitioner maintains collaborative relationships, the nurse  
26 practitioner shall complete and maintain a form, created by the depart-  
27 ment, to which the nurse practitioner shall attest, that describes such  
28 collaborative relationships. For purposes of this paragraph, "collabora-

1 tive relationships" shall mean that the nurse practitioner shall commu-  
2 nicate, whether in person, by telephone or through written (including  
3 electronic) means, with a licensed physician qualified to collaborate in  
4 the specialty involved or, in the case of a hospital, communicate with a  
5 licensed physician qualified to collaborate in the specialty involved  
6 and having privileges at such hospital, for the purposes of exchanging  
7 information, as needed, in order to provide comprehensive patient care  
8 and to make referrals as necessary. Such form shall also reflect the  
9 nurse practitioner's acknowledgement that if reasonable efforts to  
10 resolve any dispute that may arise with the collaborating physician or,  
11 in the case of a collaboration with a hospital, with a licensed physi-  
12 cian qualified to collaborate in the specialty involved and having priv-  
13 ileges at such hospital, about a patient's care are not successful, the  
14 recommendation of the physician shall prevail. Such form shall be  
15 updated as needed and may be subject to review by the department. The  
16 nurse practitioner shall maintain documentation that supports such  
17 collaborative relationships. Failure to comply with the requirements  
18 found in this paragraph by a nurse practitioner who is not complying  
19 with such provisions of paragraph (a) of this subdivision, shall be  
20 subject to professional misconduct provisions as set forth in article  
21 one hundred thirty of this title.

22 (ii) a nurse practitioner, certified under section sixty-nine  
23 hundred ten of this article and practicing for more than three thousand  
24 six hundred hours in primary care, shall be exempt from the requirements  
25 of subparagraph (i) of paragraph (a) of this subdivision. For purposes  
26 of this paragraph, "primary care" shall include but not be limited to  
27 general pediatrics, general adult medicine, general geriatric medicine,

1 general internal medicine, obstetrics and gynecology, family medicine,  
2 or such other related areas as determined by the commissioner of health.

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

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

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

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

21 a. specify the medication-related tasks that may be performed by  
22 certified medication aides pursuant to this subdivision. Such tasks  
23 shall include the administration of medications which are routine and  
24 pre-filled or otherwise packaged in a manner that promotes relative ease  
25 of administration, provided that administration of medications by  
26 injection, sterile procedures, and central line maintenance shall be  
27 prohibited. Provided, however, such prohibition shall not apply to  
28 injections of insulin or other injections for diabetes care, to

1 injections of low molecular weight heparin, and to pre-filled auto-in-  
2 jections of naloxone and epinephrine for emergency purposes, and  
3 provided, further, that entities employing certified medication aides  
4 pursuant to this subdivision shall establish a systematic approach to  
5 address drug diversion;

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

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

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

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

27 (iii) authorizing multiple registered professional nurses to jointly  
28 agree to assign medication-related tasks to a certified medication aide,



1 provided further that only one registered professional nurse shall be  
2 required to determine if the certified medication aide has demonstrated  
3 competency in the medication-related task to be performed;

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

7 e. provide that only a certified nurse aide may perform medication-re-  
8 lated tasks as a certified medication aide when such aide has:

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

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

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

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

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

16 (vi) completed the requisite training and demonstrated competencies of  
17 a certified medication aide as determined by the commissioner in consul-  
18 tation with the commissioner of health;

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

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

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

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

1 h. provide that a certified medication aide shall not be authorized to  
2 perform any medication-related tasks or activities pursuant to this  
3 subdivision that are outside the scope of practice of a licensed practi-  
4 cal nurse or any medication-related tasks that have not been appropri-  
5 ately assigned by the supervising registered professional nurse;

6 i. provide that a certified medication aide shall document all medica-  
7 tion-related tasks provided to an individual, including medication  
8 administration to each individual through the use of a medication admin-  
9 istration record; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 § 13. This act shall take effect immediately and shall be deemed to  
19 have been in full force and effect on and after April 1, 2022; provided,  
20 however, that sections six, seven and eight of this act shall expire and  
21 be deemed repealed two years after it shall have become a law.

22 PART D

23 Section 1. The social services law is amended by adding a new section  
24 367-w to read as follows:

25 § 367-w. Health care and mental hygiene worker bonuses. 1. Purpose  
26 and intent. New York's essential front line health care and mental

1 hygiene workers have seen us through a once-in-a-century public health  
2 crisis and turned our state into a model for battling and beating  
3 COVID-19. To attract talented people into the profession at a time of  
4 such significant strain while also retaining those who have been working  
5 so tirelessly these past two years, we must recognize the efforts of our  
6 health care and mental hygiene workforce and reward them financially for  
7 their service.

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

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

17 (a) "Employee" means certain front line health care and mental hygiene  
18 practitioners, technicians, assistants and aides that provide hands on  
19 health or care services to individuals, without regard to whether the  
20 person works full-time, part-time, on a salaried, hourly, or temporary  
21 basis, or as an independent contractor, that received an annualized base  
22 salary of one hundred thousand dollars or less, to include such titles  
23 as determined by the commissioner, in consultation with the commissioner  
24 of mental health, the commissioner for people with developmental disa-  
25 bilities, the commissioner of addiction services and supports, and the  
26 commissioner of children and family services, as applicable, and  
27 approved by the director of budget.

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

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

17 (ii) programs funded by the office of mental health, the office of  
18 addiction services and supports, or the office for people with develop-  
19 mental disabilities; and

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

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

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

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

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

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

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

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

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

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

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

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

27 (b) Notwithstanding paragraph (a) of this subdivision, the commission-  
28 er may through regulation specify an alternative number of vesting peri-



1 ods, provided that total payments do not exceed three thousand dollars  
2 per employee.

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

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

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

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

21 5. Audits, investigations and reviews. (a) The Medicaid inspector  
22 general shall, in coordination with the commissioner, conduct audits,  
23 investigations and reviews of employers required to submit claims under  
24 this section. Such claims, inappropriately paid, under this section  
25 shall constitute overpayments as that term is defined under the regu-  
26 lations governing the medical assistance program. The Medicaid inspector  
27 general may recover such overpayments to employers as it would an over-  
28 payment under the medical assistance program, impose sanctions up to and

1 including exclusion from the medical assistance program, impose penal-  
2 ties, and take any other action authorized by law where:

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

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

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

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

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

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

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

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

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

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

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

13 (vi) For purposes of this paragraph, "person" as used in subparagraph  
14 (i) of this paragraph does not include recipients of the medical assist-  
15 ance program; and "person" as used in subparagraphs (ii) [--], (iii) and  
16 (iv) of this paragraph, is as defined in paragraph (e) of subdivision  
17 [(6)] six of section three hundred sixty-three-d of this [chapter] arti-  
18 cle; and "person" as used in subparagraph (v) of this paragraph includes  
19 employers as defined in section three hundred sixty-seven-w of this  
20 article.

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

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

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

3 § 4. Health care and mental hygiene worker bonuses for state employ-  
4 ees. 1. An employee who is employed by a state operated facility, an  
5 institutional or direct-care setting operated by the executive branch of  
6 the State of New York or a public hospital operated by the state univer-  
7 sity of New York and who is deemed substantially equivalent to the defi-  
8 nition of employee pursuant to paragraph (a) of subdivision 2 of section  
9 367-w of the social services law as determined by the commissioner of  
10 health, in consultation with the chancellor of the state university of  
11 New York, the commissioner of the department of civil service, the  
12 director of the office of employee relations, and the commissioners of  
13 other state agencies, as applicable, and approved by the director of  
14 budget, shall be eligible for the health care and mental hygiene worker  
15 bonus. Such bonus shall only be paid to employees that receive an annu-  
16 alized base salary of one hundred thousand dollars or less.

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

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

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

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

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

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

16 § 7. This act shall take effect immediately.

17 PART E

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

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

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

14 § 2. Subdivision 2 of section 605 of the public health law, as amended  
15 by section 1 of part 0 of chapter 57 of the laws of 2019, is amended to  
16 read as follows:

17 2. State aid reimbursement for public health services provided by a  
18 municipality under this title, shall be made if the municipality is  
19 providing some or all of the core public health services identified in  
20 section six hundred two of this title, pursuant to an approved applica-  
21 tion for state aid, at a rate of no less than thirty-six per centum,  
22 except for the city of New York which shall receive no less than twenty  
23 per centum, of the difference between the amount of moneys expended by  
24 the municipality for public health services required by section six  
25 hundred two of this title during the fiscal year and the base grant  
26 provided pursuant to subdivision one of this section. Provided, however,  
27 that a municipality's fringe benefit costs shall be eligible for  
28 reimbursement at a fringe benefit rate not to exceed fifty per centum,

1 as defined by section six hundred sixteen of this article. No such  
2 reimbursement shall be provided for services that are not eligible for  
3 state aid pursuant to this article.

4 § 3. Subdivisions 1 and 2 of section 616 of the public health law,  
5 subdivision 1 as amended by section 2 of part 0 of chapter 57 of the  
6 laws of 2019 and subdivision 2 as added by chapter 901 of the laws of  
7 1986, are amended, and a new subdivision 4 is added to read as follows:

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

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

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

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

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

5 PART F

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

8 1-a. The state emergency medical services council shall advise the  
9 commissioner on such issues as the commissioner may require related to  
10 the provision of emergency medical service, specialty care, designated  
11 facility care, and disaster medical care, and assist in the coordination  
12 of such. This shall include, but is not limited to, the recommendation,  
13 periodic revision, and application of rules and regulations, appropri-  
14 ateness review standards, treatment protocols, and quality improvement  
15 standards. The state emergency medical services council shall meet as  
16 frequently as determined necessary by the commissioner.

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

19 1-a. Each regional emergency medical services council shall advise the  
20 state emergency medical services council, the commissioner and the  
21 department on such issues as the state emergency medical services coun-  
22 cil, the commissioner and the department may require, related to the  
23 provision of emergency medical service, specialty care, designated  
24 facility care, and disaster medical care, and assist in the regional  
25 coordination of such.



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

3 § 3004. Emergency medical services quality and sustainability assur-  
4 ance program. The commissioner, with the advice of the state emergency  
5 medical advisory committee, may create an emergency medical services  
6 quality and sustainability assurance program. Standards and require-  
7 ments of the quality and sustainability assurance program may include  
8 but not be limited to: clinical standards, quality metrics, safety stan-  
9 dards, emergency vehicle operator standards, clinical competencies,  
10 sustainability metrics and minimum requirements for quality assurance  
11 and sustainability assurance programs to be followed by emergency  
12 medical services agencies, to promote positive patient outcomes, safety,  
13 and emergency medical services system sustainability throughout the  
14 state. The commissioner is hereby authorized to promulgate regulations  
15 related to the standards and requirements of the quality and sustaina-  
16 bility assurance program. Quality and sustainability assurance programs  
17 shall require each emergency medical services agency to perform regular  
18 and periodic review of quality and sustainability assurance program  
19 metrics, identification of agency deficiencies and strengths, develop-  
20 ment of programs to improve agency metrics, strengthen system sustaina-  
21 bility, and continuous monitoring of care provided. The department may  
22 contract for services to assist in the oversight of these metrics state-  
23 wide with subject matter experts to assist in the oversight of these  
24 metrics statewide. The department may delegate authority to oversee  
25 these metrics and regulations to counties or other contractors as deter-  
26 mined by the commissioner. Emergency medical services agencies that do  
27 not meet the standards and requirements set forth in the quality assur-  
28 ance program set by the commissioner may be subject to enforcement

1 actions, including but not limited to revocation, suspension, perform-  
2 ance improvement plans, or restriction from specific types of response  
3 such as but not limited to suspension of ability to respond to requests  
4 for emergency medical assistance or to perform emergency medical  
5 services.

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

8 § 3018. Statewide comprehensive emergency medical system plan. 1. The  
9 department, in consultation with the state emergency medical advisory  
10 committee, shall develop and maintain a statewide comprehensive emergen-  
11 cy medical system plan that shall provide for a coordinated emergency  
12 medical system in New York state, including but not be limited to:

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

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

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

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

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

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

11 4. Each county shall develop and maintain a comprehensive county emer-  
12 gency medical system plan that shall provide for a coordinated emergency  
13 medical system within the county. The county office of emergency medical  
14 services shall be responsible for the development and maintenance of the  
15 comprehensive county emergency medical system plan. Such plans shall be  
16 subject to review by the regional emergency medical advisory committee,  
17 the state advisory council and approval by the department. The depart-  
18 ment shall be responsible for oversight of each county's compliance with  
19 their plan.

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

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

24 § 3019. Emergency medical systems training program. 1. There is hereby  
25 established a training program for emergency medical systems that  
26 includes students, emergency medical service practitioners, agencies,  
27 facilities, and personnel, and the commissioner may provide funding  
28 within the amount appropriated to conduct such training programs. Until

1 such time as the department announces the training program pursuant to  
2 this section is in effect, all current standards, curriculums, and  
3 requirements for students, emergency medical service practitioners,  
4 agencies, facilities, and personnel shall remain in effect.

5 2. The department, in consultation with the state emergency medical  
6 advisory council, shall establish minimum education standards, curric-  
7 ulums and requirements for all emergency medical system training  
8 programs. No person shall profess to provide emergency medical system  
9 training without the approval of the department.

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

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

18 5. The commissioner shall, within amounts appropriated, establish a  
19 public service campaign to recruit additional personnel into the emer-  
20 gency medical system fields.

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

25 7. The department may create or adopt with the approval of the commis-  
26 sioner additional standards, training and criteria to become a credent-  
27 ialled emergency medical service practitioner to provide specialized,

1 advanced, or other services that further support or advance the emergen-  
2 cy medical system.

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

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

25 (b) Notwithstanding the provisions of paragraph (a) of this subdivi-  
26 sion, the commissioner may promulgate regulations to provide for the  
27 issuance of an emergency medical system agency certificate without a  
28 determination of public need.

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

4 1. "Emergency medical service" means [initial emergency medical  
5 assistance including, but not limited to, the treatment of trauma,  
6 burns, respiratory, circulatory and obstetrical emergencies] care of a  
7 person to, from, at, in, or between the person's home, scene of injury,  
8 hospitals, health care facilities, public events or other locations, by  
9 emergency medical services practitioners as a patient care team member,  
10 for emergency, non-emergency, specialty, low acuity, preventative, or  
11 interfacility care; emergency and non-emergency medical dispatch; coor-  
12 dination of emergency medical system equipment and personnel; assess-  
13 ment; treatment, transportation, routing, referrals and communications  
14 with treatment facilities and medical personnel; public education, inju-  
15 ry prevention and wellness initiatives; administration of immunizations  
16 as approved by the state emergency medical services council; and  
17 follow-up and restorative care.

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

20 PART G

21 Section 1. Notwithstanding any other provision of law, rule, or regu-  
22 lation to the contrary, the following articles of title 8 of the educa-  
23 tion law governing the healthcare professions are hereby REPEALED and  
24 all removed provisions, and all powers authorized pursuant to such  
25 provisions, are hereby added to the public health law under the authori-  
26 ty of the commissioner of health, pursuant to a plan to be proposed not

1 inconsistent with this section, which shall include the text of the new  
2 laws to be adopted.

3 Article 131 MEDICINE

4 Article 131-A DEFINITIONS OF PROFESSIONAL MISCONDUCT APPLICABLE TO  
5 PHYSICIANS, PHYSICIAN'S ASSISTANTS AND SPECIALIST'S ASSISTANTS

6 Article 131-B PHYSICIAN ASSISTANTS

7 Article 131-C SPECIALIST ASSISTANTS

8 Article 132 CHIROPRACTIC

9 Article 133 DENTISTRY, DENTAL HYGIENE, AND REGISTERED DENTAL ASSISTING

10 Article 134 LICENSED PERFUSIONISTS

11 Article 136 PHYSICAL THERAPY AND PHYSICAL THERAPIST ASSISTANTS

12 Article 137 PHARMACY

13 Article 137-A REGISTERED PHARMACY TECHNICIANS

14 Article 139 NURSING

15 Article 140 PROFESSIONAL MIDWIFERY PRACTICE ACT

16 Article 141 PODIATRY

17 Article 143 OPTOMETRY

18 Article 144 OPHTHALMIC DISPENSING

19 Article 153 PSYCHOLOGY

20 Article 154 SOCIAL WORK

21 Article 155 MASSAGE THERAPY

22 Article 156 OCCUPATIONAL THERAPY

23 Article 157 DIETETICS AND NUTRITION

24 Article 159 SPEECH-LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS

25 Article 160 ACUPUNCTURE

26 Article 162 ATHLETIC TRAINERS

27 Article 163 MENTAL HEALTH PRACTITIONERS

28 Article 164 RESPIRATORY THERAPISTS AND RESPIRATORY THERAPY TECHNICIANS

1 Article 165 CLINICAL LABORATORY TECHNOLOGY PRACTICE ACT

2 Article 166 MEDICAL PHYSICS PRACTICE

3 Article 167 APPLIED BEHAVIOR ANALYSIS

4 Article 168 LICENSED PATHOLOGISTS' ASSISTANTS

5 § 2. Transfer of functions, powers, duties and obligations. Notwith-  
6 standing any inconsistent provisions of law to the contrary, effective  
7 January 1, 2023, all functions, powers, duties and obligations of the  
8 education department concerning the professions of medicine, physicians,  
9 physicians assistants, specialist assistants, chiropractic, dentistry,  
10 dental hygiene, registered dental assisting, perfusionists, physical  
11 therapy, physical therapy assistants, pharmacy, registered pharmacy  
12 technicians, nursing, professional midwifery, podiatry, optometry,  
13 ophthalmic dispensing, psychology, social work, massage therapy, occupa-  
14 tional therapy, dietetics and nutrition, speech-language pathologists  
15 and audiologist, acupuncture, athletic trainers, mental health practi-  
16 tioners, respiratory therapists, respiratory therapy technicians, clin-  
17 ical laboratory technology, medical physics, applied behavior analysis,  
18 and licensed pathologists' assistants under title 8 of the education law  
19 shall be transferred to the New York state department of health.

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

25 § 4. Continuity of authority. For the purpose of all functions,  
26 powers, duties and obligations of the state education department trans-  
27 ferred to and assumed by the department of health, the department of  
28 health shall continue the operation of the provisions previously done by



1 the state education department, pursuant to sections one through nine of  
2 this act.

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

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

17 § 7. Terms occurring in laws, contracts and other documents. When-  
18 ever the state education department is referred to or designated in any  
19 law, contract or document pertaining to the functions, powers, obli-  
20 gations and duties hereby transferred and assigned, such reference or  
21 designation shall be deemed to refer to department of health or the  
22 commissioner thereof.

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

26 § 9. Pending actions or proceedings. No action or proceeding pending  
27 at the time when sections one through nine of this act shall take effect  
28 relating to the functions, powers and duties of the state education

1 department transferred pursuant to sections one through nine of this  
2 act, brought by or against the state education department or board of  
3 regents shall be affected by any provision of sections one through one  
4 hundred forty of this act, but the same may be prosecuted or defended in  
5 the name of commissioner of the department of health. In all such  
6 actions and proceedings, the commissioner of health, upon application to  
7 the court, shall be substituted as a party.

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

9 PART H

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

15 1. Notwithstanding any inconsistent provision of state law, rule or  
16 regulation to the contrary, subject to federal approval, the year to  
17 year rate of growth of department of health state funds Medicaid spend-  
18 ing shall not exceed the [ten] five year rolling average of the [medical  
19 component of the consumer price index as published by the United States  
20 department of labor, bureau of labor statistics,] Medicaid spending  
21 annual growth rate projections within the National Health Expenditure  
22 Accounts produced by the office of the actuary in the federal Centers  
23 for Medicare and Medicaid services for the preceding [ten] five years;  
24 provided, however, that for state fiscal year 2013-14 and for each  
25 fiscal year thereafter, the maximum allowable annual increase in the  
26 amount of department of health state funds Medicaid spending shall be

1 calculated by multiplying the department of health state funds Medicaid  
2 spending for the previous year, minus the amount of any department of  
3 health state operations spending included therein, by such [ten] five  
4 year rolling average.

5 § 2. Paragraph (a) of subdivision 1 of section 92 of part H of chapter  
6 59 of the laws of 2011, amending the public health law and other laws  
7 relating to relating to known and projected department of health state  
8 fund Medicaid expenditures, as amended by section 1 of part A of chapter  
9 57 of the laws of 2021, is amended to read as follows:

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

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

19 PART I

20 Section 1. 1. Notwithstanding any provision of law to the contrary,  
21 for the state fiscal years beginning April 1, 2022 and ending on March  
22 31, 2024, all department of health Medicaid payments made for services  
23 provided on and after April 1, 2022, shall be subject to a uniform rate  
24 increase of one percent, subject to the approval of the commissioner of  
25 the department of health and director of the budget. Such rate increase  
26 shall be subject to federal financial participation.

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

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

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

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

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

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

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

20 PART J

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

24 (c) The base period reported costs and statistics used for rate-set-  
25 ting for operating cost components, including the weights assigned to  
26 diagnostic related groups, shall be updated no less frequently than

1 every four years and the new base period [shall] may be no more than  
2 four years prior to the first applicable rate period that utilizes such  
3 new base period provided, however, that the first updated base period  
4 shall begin on or after April first, two thousand fourteen, but no later  
5 than July first, two thousand fourteen; and further provided that the  
6 updated base period subsequent to July first, two thousand eighteen  
7 shall begin on or after January first, two thousand twenty-four.

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

10 PART K

11 Section 1. The public health law is amended by adding a new section  
12 2825-g to read as follows:

13 § 2825-g. Health care facility transformation program: statewide IV.

14 1. A statewide health care facility transformation program is hereby  
15 established within the department for the purpose of transforming, rede-  
16 signing, and strengthening quality health care services in alignment  
17 with statewide and regional health care needs, and in the ongoing  
18 pandemic response. The program shall also provide funding, subject to  
19 lawful appropriation, in support of capital projects that facilitate  
20 furthering such transformational goals.

21 2. The commissioner shall enter into an agreement with the dormitory  
22 authority of the state of New York pursuant to section sixteen hundred  
23 eighty-r of the public authorities law, which shall apply to this agree-  
24 ment, subject to the approval of the director of the division of the  
25 budget, for the purposes of the distribution, and administration of  
26 available funds, pursuant to such agreement, and made available pursuant

1 to this section and appropriation. Such funds may be awarded and  
2 distributed by the department for grants to health care facilities  
3 including but not limited to, hospitals, residential health care facili-  
4 ties, adult care facilities licensed under title two of article seven of  
5 the social services law, diagnostic and treatment centers, and clinics  
6 licensed pursuant to this chapter or the mental hygiene law, children's  
7 residential treatment facilities licensed pursuant to article thirty-one  
8 of the mental hygiene law, assisted living programs approved by the  
9 department pursuant to section four hundred sixty-one-1 of the social  
10 services law, behavioral health facilities licensed pursuant to articles  
11 thirty-one and thirty-two of the mental hygiene law, and independent  
12 practice associations or organizations. A copy of such agreement, and  
13 any amendments thereto, shall be provided by the department to the chair  
14 of the senate finance committee, the chair of the assembly ways and  
15 means committee, and the director of the division of the budget no later  
16 than thirty days after such agreement is finalized. Projects awarded,  
17 in whole or part, under sections twenty-eight hundred twenty-five-a and  
18 twenty-eight hundred twenty-five-b of this article shall not be eligible  
19 for grants or awards made available under this section.

20 3. Notwithstanding subdivision two of this section or any inconsistent  
21 provision of law to the contrary, and upon approval of the director of  
22 the budget, the commissioner may, subject to the availability of lawful  
23 appropriation, award up to four hundred fifty million dollars of the  
24 funds made available pursuant to this section for unfunded project  
25 applications submitted in response to the request for application number  
26 18406 issued by the department on September thirtieth, two thousand  
27 twenty-one pursuant to section twenty-eight hundred twenty-five-f of  
28 this article. Authorized amounts to be awarded pursuant to applications

1 submitted in response to the request for application number 18406 shall  
2 be awarded no later than December thirty-first, two thousand twenty-two.  
3 Provided, however, that a minimum of:

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

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

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

20 4. Notwithstanding sections one hundred twelve and one hundred sixty-  
21 three of the state finance law, sections one hundred forty-two and one  
22 hundred forty-three of the economic development law, or any inconsistent  
23 provision of law to the contrary, up to two hundred million dollars of  
24 the funds appropriated for this program shall be awarded, without a  
25 competitive bid or request for proposal process, for grants to health  
26 care providers for purposes of modernization of an emergency department  
27 of regional significance. For purposes of this subdivision, an emergency  
28 department shall be considered to have regional significance if it: (a)

1 serves as Level 1 trauma center with the highest volume in its region;  
2 (b) includes the capacity to segregate patients with communicable  
3 diseases, trauma or severe behavioral health issues from other patients  
4 in the emergency department; (c) provides training in emergency care and  
5 trauma care to residents from multiple hospitals in the region; and (d)  
6 serves a high proportion of Medicaid patients.

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

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

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

26 7. Notwithstanding sections one hundred twelve and one hundred sixty-  
27 three of the state finance law, sections one hundred forty-two and one  
28 hundred forty-three of the economic development law, or any inconsistent



1 provision of law to the contrary, up to fifty million dollars of the  
2 funds appropriated for this program shall be awarded, without a compet-  
3 itive bid or a request for proposal process, to residential and communi-  
4 ty-based alternatives to the traditional model of nursing home care.

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

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

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

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

4 3. The public health and health planning council shall not approve a  
5 certificate of incorporation, articles of organization or application  
6 for establishment unless it is satisfied, insofar as applicable, as to  
7 (a) the public need for the existence of the institution at the time and  
8 place and under the circumstances proposed, provided, however, that in  
9 the case of an institution proposed to be established or operated by an  
10 organization defined in subdivision one of section one hundred seventy-  
11 two-a of the executive law, the needs of the members of the religious  
12 denomination concerned, for care or treatment in accordance with their  
13 religious or ethical convictions, shall be deemed to be public need; (b)  
14 the character, competence, and standing in the community, of the  
15 proposed incorporators, directors, sponsors, stockholders, members,  
16 controlling persons, or operators; with respect to any proposed incorpo-  
17 rator, director, sponsor, stockholder, member, controlling person, or  
18 operator who is already or within the past [ten] seven years [has] been  
19 an incorporator, director, sponsor, member, principal stockholder, prin-  
20 cipal member, controlling person, or operator any hospital or other  
21 health-related or long-term care facility, program or agency, including  
22 but not limited to, private proprietary home for adults, residence for  
23 adults, or non-profit home for the aged or blind which has been issued  
24 an operating certificate by the state department of social services, or  
25 a halfway house, hostel or other residential facility or institution for  
26 the care, custody or treatment of the mentally disabled which is subject  
27 to approval by the department of mental hygiene, no approval shall be  
28 granted unless the public health and health planning council, having

1 afforded an adequate opportunity to members of health systems agencies,  
2 if any, having geographical jurisdiction of the area where the institu-  
3 tion is to be located to be heard, shall affirmatively find by substan-  
4 tial evidence as to each such incorporator, director, sponsor, member,  
5 principal stockholder, principal member, controlling person, or operator  
6 that a substantially consistent high level of care is being or was being  
7 rendered in each such hospital, home, residence, halfway house, hostel,  
8 or other residential facility or institution [with] in which such person  
9 is or was affiliated; for the purposes of this paragraph, the public  
10 health and health planning council shall adopt rules and regulations,  
11 subject to the approval of the commissioner, to establish the criteria  
12 to be used to determine whether a substantially consistent high level of  
13 care has been rendered, provided, however, that there shall not be a  
14 finding that a substantially consistent high level of care has been  
15 rendered where there have been violations of the state hospital code, or  
16 other applicable rules and regulations, that (i) threatened to directly  
17 affect the health, safety or welfare of any patient or resident, and  
18 (ii) were recurrent or were not promptly corrected; (c) the financial  
19 resources of the proposed institution and its sources of future reven-  
20 ues; and (d) such other matters as it shall deem pertinent.

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

24 (b) [(i)] Any transfer, assignment or other disposition of [ten  
25 percent or more of] an interest, stock, or voting rights in a sole  
26 proprietorship, partnership [or], limited liability company, non-for-  
27 profit corporation, or corporation which is the operator of a hospital  
28 [to a new partner or member] or any transfer, assignment or other dispo-

1 sition which results in the ownership or control of an interest, stock,  
2 or voting rights in that operator, shall be approved by the public  
3 health and health planning council, in accordance with the provisions of  
4 subdivisions two [and], three, and three-b of this section, except that:

5 [(A) any such change shall be subject to the approval by the public]

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

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

18 (iii) No prior approval of the public health and health planning coun-  
19 cil shall be required with respect to a transfer, assignment or disposi-  
20 tion [involving less than ten percent of], directly or indirectly, of:

21 (A) an interest, stock, or voting rights of less than ten percent in  
22 [such partnership or limited liability company] the operator, to [a new]  
23 any person, partner [or], member, [no prior approval of the public  
24 health and health planning council shall be required] or stockholder who  
25 has not been previously approved by the public health and health plan-  
26 ning council, or its predecessor for that operator. However, no such  
27 transaction shall be effective unless at least ninety days prior to the  
28 intended effective date thereof, the [partnership or limited liability

1 company] operator fully completes and files with the public health and  
2 health planning council notice on a form, to be developed by the public  
3 health and health planning council, which shall disclose such informa-  
4 tion as may reasonably be necessary for the department to recommend and  
5 for the public health and health planning council to determine whether  
6 it should bar the transaction for any of the reasons set forth in [item  
7 (A), (B), (C) or (D)] clause one, two, three or four below, and has  
8 fully responded to any request for additional information by the depart-  
9 ment acting on behalf of the public health and health planning council  
10 during the review period. Such transaction will be final upon completion  
11 of the review period, which shall be no longer than ninety days from the  
12 date the department receives a complete response to its final request  
13 for additional information, unless, prior thereto, the public health and  
14 health planning council has notified each party to the proposed trans-  
15 action that it has barred such transactions. [Within ninety days from  
16 the date of receipt of such notice, the] The public health and health  
17 planning council may bar any transaction under this subparagraph: [(A)]  
18 (1) if the equity position of the partnership [or], limited liability  
19 company, or corporation that operates a hospital for profit, determined  
20 in accordance with generally accepted accounting principles, would be  
21 reduced as a result of the transfer, assignment or disposition; [(B)]  
22 (2) if the transaction would result in the ownership of a partnership or  
23 membership interest or stock by any persons who have been convicted of a  
24 felony described in subdivision five of section twenty-eight hundred six  
25 of this article; [(C)] (3) if there are reasonable grounds to believe  
26 that the proposed transaction does not satisfy the character and compe-  
27 tence criteria set forth in subdivision three or three-b of this  
28 section; or [(D)] (4) if the transaction, together with all transactions

1 under this subparagraph for the [partnership, or successor,] operator  
2 during any five year period would, in the aggregate, involve twenty-five  
3 percent or more of the interest in the [partnership] operator. The  
4 public health and health planning council shall state specific reasons  
5 for barring any transaction under this subparagraph and shall so notify  
6 each party to the proposed transaction[.]; or

7 [(iii) With respect to a transfer, assignment or disposition of] (B)  
8 an interest, stock, or voting rights [in such partnership or limited  
9 liability company] to any [remaining] person, partner [or], member,  
10 [which transaction involves the withdrawal of the transferor from the  
11 partnership or limited liability company, no prior approval of the  
12 public health and health planning council shall be required] or stock-  
13 holder, previously approved by the public health and health planning  
14 council, or its predecessor, for that operator. However, no such trans-  
15 action shall be effective unless at least ninety days prior to the  
16 intended effective date thereof, the [partnership or limited liability  
17 company] operator fully completes and files with the public health and  
18 health planning council notice on a form, to be developed by the public  
19 health and health planning council, which shall disclose such informa-  
20 tion as may reasonably be necessary for the department to recommend and  
21 for the public health and health planning council to determine whether  
22 it should bar the transaction for the reason set forth below, and has  
23 fully responded to any request for additional information by the depart-  
24 ment acting on behalf of the public health and health planning council  
25 during the review period. Such transaction will be final upon completion  
26 of the review period, which shall be no longer than ninety days from the  
27 date the department receives a complete response to its final request  
28 for additional information, unless, prior thereto, the public health and

1 health planning council has notified each party to the proposed trans-  
2 action that it has barred such transactions. [Within ninety days from  
3 the date of receipt of such notice, the] The public health and health  
4 planning council may bar any transaction under this subparagraph if the  
5 equity position of the partnership [or], limited liability company, or  
6 corporation that operates a hospital for profit, determined in accord-  
7 ance with generally accepted accounting principles, would be reduced as  
8 a result of the transfer, assignment or disposition. The public health  
9 and health planning council shall state specific reasons for barring any  
10 transaction under this subparagraph and shall so notify each party to  
11 the proposed transaction.

12 (c) [Any transfer, assignment or other disposition of ten percent or  
13 more of the stock or voting rights thereunder of a corporation which is  
14 the operator of a hospital or which is a member of a limited liability  
15 company which is the operator of a hospital to a new stockholder, or any  
16 transfer, assignment or other disposition of the stock or voting rights  
17 thereunder of such a corporation which results in the ownership or  
18 control of more than ten percent of the stock or voting rights there-  
19 under of such corporation by any person not previously approved by the  
20 public health and health planning council, or its predecessor, for that  
21 corporation shall be subject to approval by the public health and health  
22 planning council, in accordance with the provisions of subdivisions two  
23 and three of this section and rules and regulations pursuant thereto;  
24 except that: any such transaction shall be subject to the approval by  
25 the public health and health planning council in accordance with para-  
26 graph (b) of subdivision three of this section only with respect to a  
27 new stockholder or a new principal stockholder; and shall not be subject  
28 to paragraph (a) of subdivision three of this section. In the absence of

1 such approval, the operating certificate of such hospital shall be  
2 subject to revocation or suspension. No prior approval of the public  
3 health and health planning council shall be required with respect to a  
4 transfer, assignment or disposition of ten percent or more of the stock  
5 or voting rights thereunder of a corporation which is the operator of a  
6 hospital or which is a member of a limited liability company which is  
7 the owner of a hospital to any person previously approved by the public  
8 health and health planning council, or its predecessor, for that corpo-  
9 ration. However, no such transaction shall be effective unless at least  
10 ninety days prior to the intended effective date thereof, the stockhold-  
11 er completes and files with the public health and health planning coun-  
12 cil notice on forms to be developed by the public health and health  
13 planning council, which shall disclose such information as may reason-  
14 ably be necessary for the public health and health planning council to  
15 determine whether it should bar the transaction. Such transaction will  
16 be final as of the intended effective date unless, prior thereto, the  
17 public health and health planning council shall state specific reasons  
18 for barring such transactions under this paragraph and shall notify each  
19 party to the proposed transaction.] Nothing in this [paragraph] subdivi-  
20 sion shall be construed as permitting [a] any person, partner, member,  
21 or stockholder not previously approved by the public health and health  
22 planning council for that [corporation] operator to [become the owner  
23 of] own or control, directly or indirectly, ten percent or more of the  
24 interest, stock, or voting rights of [a] any partnership, limited  
25 liability company, not-for-profit corporation, or corporation which is  
26 the operator of a hospital or a corporation which is a member of a  
27 limited liability company which is the owner of a hospital without first  
28 obtaining the approval of the public health and health planning council.



1 In the absence of approval by the public health and health planning  
2 council as required under this subdivision, the operating certificate of  
3 such hospital shall be subject to revocation or suspension. Failure to  
4 provide notice as required under this subdivision may subject the oper-  
5 ating certificate of such operator to revocation or suspension.

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

10 § 3611-a. Change in the operator or owner. 1. Any [change in the  
11 person who, or any] transfer, assignment, or other disposition of an  
12 interest, stock, or voting rights [of ten percent or more] in a sole  
13 proprietorship, partnership, limited liability company, not-for-profit  
14 corporation or corporation which is the operator of a licensed home care  
15 services agency or a certified home health agency, or any transfer,  
16 assignment or other disposition which results in the ownership or  
17 control of an interest, stock, or voting rights [of ten percent or  
18 more,] in [a limited liability company or a partnership which is the]  
19 that operator [of a licensed home care services agency or a certified  
20 home health agency], shall be approved by the public health and health  
21 planning council, in accordance with the provisions of subdivision four  
22 of section thirty-six hundred five of this article relative to licensure  
23 or subdivision two of section thirty-six hundred six of this article  
24 relative to certificate of approval, except that:

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

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

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

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

11 (i) an interest, stock, or voting rights to any person, partner,  
12 member, or stockholder previously approved by the public health and  
13 health planning council, or its predecessor, for that operator. However,  
14 no such transaction shall be effective unless at least ninety days prior  
15 to the intended effective date thereof, the operator completes and files  
16 with the public health and health planning council notice on forms to be  
17 developed by the public health and health planning council, which shall  
18 disclose such information as may reasonably be necessary for the depart-  
19 ment to recommend and for the public health and health planning council  
20 to determine whether it should bar the transaction, and has fully  
21 responded to any request for additional information by the department  
22 acting on behalf of the public health and health planning council during  
23 the review period. Such transaction will be final upon completion of the  
24 review period, which shall be no longer than ninety days from the date  
25 the department receives a complete response to its final request for  
26 additional information, unless, prior thereto, the public health and  
27 health planning council has notified each party to the proposed trans-

1 action that it has barred such transactions under this paragraph and has  
2 stated specific reasons for barring such transactions; or

3 (ii) an interest, stock, or voting rights of less than ten percent in  
4 the operator to any person, partner, member, or stockholder who has not  
5 been previously approved by the public health and health planning coun-  
6 cil for that operator. However, no such transaction shall be effective  
7 unless at least ninety days prior to the intended effective date there-  
8 of, the [partner or member] operator completes and files with the public  
9 health and health planning council notice on forms to be developed by  
10 the public health and health planning council, which shall disclose such  
11 information as may reasonably be necessary for the department to recom-  
12 mend and for the public health and health planning council to determine  
13 whether it should bar the transaction, and has fully responded to any  
14 request for additional information by the department acting on behalf of  
15 the public health and health planning council during the review period.  
16 Such transaction will be final [as of the intended effective date] upon  
17 completion of the review period, which shall be no longer than ninety  
18 days from the date the department receives a complete response to its  
19 final request for additional information, unless, prior thereto, the  
20 public health and health planning council [shall state] has notified  
21 each party to the proposed transaction that it has barred such trans-  
22 actions under this paragraph and has stated specific reasons for barring  
23 such transactions [under this paragraph and shall notify each party to  
24 the proposed transaction].

25 (iii) Nothing in this subdivision shall be construed as permitting any  
26 person, partner, member, or stockholder not previously approved by the  
27 public health and health planning council for that operator to own or  
28 control, directly or indirectly, ten percent or more of the interest,

1 stock, or voting rights of any partnership, limited liability company,  
2 not-for-profit corporation, or corporation which is the operator of a  
3 licensed home care services agency or a certified home health agency  
4 without first obtaining the approval of the public health and health  
5 planning council.

6 (iv) In the absence of approval by the public health and health plan-  
7 ning council as required under this paragraph, the license or certif-  
8 icate of approval of such operator shall be subject to revocation or  
9 suspension. Failure to provide notice as required under this paragraph  
10 may subject the license or certificate of approval of such operator to  
11 revocation or suspension thereof.

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

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

27 (b) With respect to certified home health agencies, such change shall  
28 not be subject to the public need assessment described in paragraph (a)

1 of subdivision two of section thirty-six hundred six of this article. In  
2 the absence of such approval, the license or certificate of approval  
3 shall be subject to revocation or suspension.

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

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

23 (b) The fees paid by certified home health agencies pursuant to this  
24 subdivision for any application approved in accordance with this section  
25 shall be deemed allowable costs in the determination of reimbursement  
26 rates established pursuant to this article. All fees pursuant to this  
27 section shall be payable to the department of health for deposit into

1 the special revenue funds - other, miscellaneous special revenue fund -  
2 339, certificate of need account.

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

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

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

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

20 (iii) No prior approval of the public health and health planning coun-  
21 cil shall be required with respect to a transfer, assignment or disposi-  
22 tion, directly or indirectly, of:

23 (A) an interest, stock, or voting rights to any person, partner,  
24 member, or stockholder previously approved by the public health and  
25 health planning council, or its predecessor, for that operator. However,  
26 no such transaction shall be effective unless at least ninety days prior  
27 to the intended effective date thereof, the operator completes and files  
28 with the public health and health planning council notice, on forms to

1 be developed by the public health and health planning council, which  
2 shall disclose such information as may reasonably be necessary for the  
3 department to recommend and for the public health and health planning  
4 council to determine whether it should bar the transaction, and has  
5 fully responded to any request for additional information by the depart-  
6 ment acting on behalf of the public health and health planning council  
7 during the review period. Such transaction will be final upon completion  
8 of the review period, which shall be no longer than ninety days from the  
9 date the department receives a complete response to its final request  
10 for additional information, unless, prior thereto, the public health and  
11 health planning council has notified each party to the proposed trans-  
12 action that it has barred such transactions under this paragraph and has  
13 stated specific reasons for barring such transactions; or

14 (B) an interest, stock, or voting rights of less than ten percent in  
15 the operator to any person, partner, member, or stockholder who has not  
16 been previously approved by the public health and health planning coun-  
17 cil for that operator. However, no such transaction shall be effective  
18 unless at least ninety days prior to the intended effective date there-  
19 of, the operator completes and files with the public health and health  
20 planning council notice on forms to be developed by the public health  
21 and health planning council, which shall disclose such information as  
22 may reasonably be necessary for the department to recommend and for the  
23 public health and health planning council to determine whether it should  
24 bar the transaction, and has fully responded to any request for addi-  
25 tional information by the department acting on behalf of the public  
26 health and health planning council during the review period. Such trans-  
27 action will be final upon completion of the review period, which shall  
28 be no longer than ninety days from the date the department receives a

1 complete response to its final request for additional information,  
2 unless, prior thereto, the public health and health planning council has  
3 notified each party to the proposed transaction that it has barred such  
4 transactions under this paragraph and has stated specific reasons for  
5 barring such transactions.

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

14 (v) In the absence of approval by the public health and health plan-  
15 ning council as required under this paragraph, the certificate of  
16 approval of such operator shall be subject to revocation or suspension.  
17 Failure to provide notice as required under this paragraph may subject  
18 the certificate of approval of such operator to revocation or suspen-  
19 sion.

20 § 5. This act shall take effect immediately.

21 PART M

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

25 (a) "Revenue" shall mean the total operating revenue from or on behalf  
26 of residents of the residential health care facility, government payers,



1 or third-party payers, to pay for a resident's occupancy of the residen-  
2 tial health care facility, resident care, and the operation of the resi-  
3 dential health care facility as reported in the residential health care  
4 facility cost reports submitted to the department; provided, however,  
5 that revenue shall exclude:

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

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

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

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

20 4. The commissioner may waive the requirements of this section on a  
21 case-by-case basis with respect to a nursing home that demonstrates to  
22 the commissioner's satisfaction that it experienced unexpected or excep-  
23 tional circumstances that prevented compliance. The commissioner may  
24 also exclude from revenues and expenses, on a case-by-case basis,  
25 extraordinary revenues and capital expenses, incurred due to a natural  
26 disaster or other circumstances set forth by the commissioner in regu-  
27 lation. The commissioner may also exclude from revenues, on a case-by-  
28 case basis, the capital per diem portion of the reimbursement rate for

1 nursing homes that have a three-star CMS rating. At least thirty days  
2 before any action by the commissioner under this subdivision, the  
3 commissioner shall transmit the proposed action to the state office of  
4 the long-term care ombudsman and the chairs of the senate and assembly  
5 health committees, and post it on the department's website.

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

9 (d) The commissioner shall promulgate regulations, and may promulgate  
10 emergency regulations, to implement the provisions of this subdivision.  
11 Such regulations shall be developed in consultation with the nursing  
12 home industry and advocates for residential health care facility resi-  
13 dents and, further, the commissioner shall provide notification concern-  
14 ing such regulations to the chairs of the senate and assembly health  
15 committees, the chair of the senate finance committee and the chair of  
16 the assembly ways and means committee. Such regulations shall include  
17 provisions for rate adjustments or payment enhancements to facilitate a  
18 minimum four-year transition of facilities to the rate-setting methodol-  
19 ogy established by this subdivision and may also include, but not be  
20 limited to, provisions for facilitating quality improvements in residen-  
21 tial health care facilities. For purposes of facilitating quality  
22 improvements through the establishment of a nursing home quality pool to  
23 be funded at the discretion of the commissioner by (i) adjustments in  
24 medical assistance rates, (ii) funds made available through state appro-  
25 priations, or (iii) a combination thereof, those facilities that  
26 contribute to the quality pool, but are deemed ineligible for quality  
27 pool payments due exclusively to a specific case of employee misconduct,  
28 shall nevertheless be eligible for a quality pool payment if the facili-

1 ty properly reported the incident, did not receive a survey citation  
2 from the commissioner or the Centers for Medicare and Medicaid Services  
3 establishing the facility's culpability with regard to such misconduct  
4 and, but for the specific case of employee misconduct, the facility  
5 would have otherwise received a quality pool payment. Regulations  
6 pertaining to the facilitation of quality improvement may be made effec-  
7 tive for periods on and after January first, two thousand thirteen.

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

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

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

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

28 (B) a federally designated critical access hospital;

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

2 (D) a residential health care facility;

3 (E) an adult care facility;

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

6 (1) such hospital has at least thirty percent of its inpatient  
7 discharges made up of Medicaid eligible individuals, uninsured individ-  
8 uals or Medicaid dually eligible individuals and with at least thirty-  
9 five percent of its outpatient visits made up of Medicaid eligible indi-  
10 viduals, uninsured individuals or Medicaid dually-eligible individuals;  
11 or

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

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

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

21 PART N

22 Section 1. Subparagraph 4 of paragraph (b) of subdivision 1 of section  
23 366 of the social services law, as added by section 1 of part D of chap-  
24 ter 56 of the laws of 2013, is amended to read as follows:

25 (4) An individual who is a pregnant woman or is a member of a family  
26 that contains a dependent child living with a parent or other caretaker

1 relative is eligible for standard coverage if [his or her MAGI] their  
2 household income does not exceed [the MAGI-equivalent of] one hundred  
3 [thirty] thirty-three percent of the [highest amount that ordinarily  
4 would have been paid to a person without any income or resources under  
5 the family assistance program as it existed on the first day of Novem-  
6 ber, nineteen hundred ninety-seven] federal poverty line for the appli-  
7 cable family size, which shall be calculated in accordance with guidance  
8 issued by the Secretary of the United States department of health and  
9 human services; for purposes of this subparagraph, the term dependent  
10 child means a person who is under eighteen years of age, or is eighteen  
11 years of age and a full-time student, who is deprived of parental  
12 support or care by reason of the death, continued absence, or physical  
13 or mental incapacity of a parent, or by reason of the unemployment of  
14 the parent, as defined by the department of health.

15 § 2. Subparagraph 2 of paragraph (c) of subdivision 1 of section 366  
16 of the social services law, as added by section 1 of part D of chapter  
17 56 of the laws of 2013, is amended to read as follows:

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

26 § 3. Subparagraph 5 of paragraph (c) of subdivision 1 of section 366  
27 of the social services law, as added by section 1 of part D of chapter  
28 56 of the laws of 2013, is amended to read as follows:

1 (5) A disabled individual at least sixteen years of age, but under the  
2 age of sixty-five, who: would be eligible for benefits under the supple-  
3 mental security income program but for earnings in excess of the allow-  
4 able limit; has net available income that does not exceed two hundred  
5 fifty percent of the applicable federal income official poverty line, as  
6 defined and updated by the United States department of health and human  
7 services, for a one-person or two-person household, as defined by the  
8 commissioner in regulation; [has household resources, as defined in  
9 paragraph (e) of subdivision two of section three hundred sixty-six-c of  
10 this title, other than retirement accounts, that do not exceed twenty  
11 thousand dollars for a one-person household or thirty thousand dollars  
12 for a two-person household, as defined by the commissioner in regu-  
13 lation;] and contributes to the cost of medical assistance provided  
14 pursuant to this subparagraph in accordance with subdivision twelve of  
15 section three hundred sixty-seven-a of this title; for purposes of this  
16 subparagraph, disabled means having a medically determinable impairment  
17 of sufficient severity and duration to qualify for benefits under  
18 section 1902(a)(10)(A)(ii)(xv) of the social security act.

19 § 4. Subparagraph 10 of paragraph (c) of subdivision 1 of section 366  
20 of the social services law, as added by section 1 of part D of chapter  
21 56 of the laws of 2013, is amended to read as follows:

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

1 to meet all the costs of required medical care and services available  
2 under this title.

3 § 5. Paragraph (a) of subdivision 2 of section 366 of the social  
4 services law, as separately amended by chapter 32 and 588 of the laws of  
5 1968, the opening paragraph as amended by chapter 41 of the laws of  
6 1992, subparagraph 1 as amended by section 27 of part C of chapter 109  
7 of the laws of 2006, subparagraphs 3 and 6 as amended by chapter 938 of  
8 the laws of 1990, subparagraph 4 as amended by section 43 and subpara-  
9 graph 7 as amended by section 47 of part C of chapter 58 of the laws of  
10 2008, subparagraph 5 as amended by chapter 576 of the laws of 2007,  
11 subparagraph 9 as amended by chapter 110 of the laws of 1971, subpara-  
12 graph 10 as added by chapter 705 of the laws of 1988, clauses (i) and  
13 (ii) of subparagraph 10 as amended by chapter 672 of the laws of 2019,  
14 clause (iii) of subparagraph 10 as amended by chapter 170 of the laws of  
15 1994, and subparagraph 11 as added by chapter 576 of the laws of 2015,  
16 is amended to read as follows:

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

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

23 (ii) for applications for medical assistance filed on or after January  
24 first, two thousand six, a homestead which is essential and appropriate  
25 to the needs of the household; provided, however, that in determining  
26 eligibility of an individual for medical assistance for nursing facility  
27 services and other long term care services, the individual shall not be  
28 eligible for such assistance if the individual's equity interest in the

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

20 (2) [essential personal property;

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

24 (4) savings in amounts equal to one hundred fifty percent of the  
25 income amount permitted under subparagraph seven of this paragraph,  
26 provided, however, that the amounts for one and two person households  
27 shall not be less than the amounts permitted to be retained by house-



1 holds of the same size in order to qualify for benefits under the feder-  
2 al supplemental security income program;

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

9 (ii) such income of a disabled person (as such term is defined in  
10 section 1614(a)(3) of the federal social security act (42 U.S.C. section  
11 1382c(a)(3)) or in accordance with any other rules or regulations estab-  
12 lished by the social security administration), that is deposited in  
13 trusts as defined in clause (iii) of subparagraph two of paragraph (b)  
14 of this subdivision in the same calendar month within which said income  
15 is received;

16 [(6)] (3) health insurance premiums;

17 [(7)] (4) income based on the number of family members in the medical  
18 assistance household, as defined in regulations by the commissioner  
19 consistent with federal regulations under title XIX of the federal  
20 social security act [and calculated as follows:

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

27 (ii) The amounts for households of three or more shall be calculated  
28 by increasing the income standard for a household of two, established

1 pursuant to clause (i) of this subparagraph, by fifteen percent for each  
2 additional household member above two, such that the income standard for  
3 a three-person household shall be one hundred fifteen percent of the  
4 income standard for a two-person household, the income standard for a  
5 four-person household shall be one hundred thirty percent of the income  
6 standard for a two-person household, and so on.

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

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

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

25 [(10)] (7) (i) A person who is receiving or is eligible to receive  
26 federal supplemental security income payments and/or additional state  
27 payments is entitled to a personal needs allowance as follows:

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

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

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

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

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

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

1 [(11)] (8) subject to the availability of federal financial partic-  
2 ipation, any amount, including earnings thereon, in a qualified NY ABLE  
3 account as established pursuant to article eighty-four of the mental  
4 hygiene law, any contributions to such NY ABLE account, and any distrib-  
5 ution for qualified disability expenses from such account; provided  
6 however, that such exemption shall be consistent with section 529A of  
7 the Internal Revenue Code of 1986, as amended.

8 § 6. Subparagraphs 1 and 2 of paragraph (b) of subdivision 2 of  
9 section 366 of the social services law, subparagraph 1 as amended by  
10 chapter 638 of the laws of 1993 and as designated by chapter 170 of the  
11 laws of 1994, subparagraph 2 as added by chapter 170 of the laws of  
12 1994, clause (iii) of subparagraph 2 as amended by chapter 187 of the  
13 laws of 2017, clause (iv) of subparagraph 2 as amended by chapter 656 of  
14 the laws of 1997 and as further amended by section 104 of part A of  
15 chapter 62 of the laws of 2011, and clause (vi) of subparagraph 2 as  
16 added by chapter 435 of the laws of 2018, are amended to read as  
17 follows:

18 (1) In establishing standards for determining eligibility for and  
19 amount of such assistance, the department shall take into account only  
20 such income [and resources], in accordance with federal requirements, as  
21 [are] is available to the applicant or recipient and as would not be  
22 required to be disregarded or set aside for future needs, and there  
23 shall be a reasonable evaluation of any such income [or resources]. The  
24 department shall not consider the availability of an option for an  
25 accelerated payment of death benefits or special surrender value pursu-  
26 ant to paragraph one of subsection (a) of section one thousand one  
27 hundred thirteen of the insurance law, or an option to enter into a  
28 viatical settlement pursuant to the provisions of article seventy-eight

1 of the insurance law, as an available resource in determining eligibil-  
2 ity for an amount of such assistance, provided, however, that the  
3 payment of such benefits shall be considered in determining eligibility  
4 for and amount of such assistance. There shall not be taken into consid-  
5 eration the financial responsibility of any individual for any applicant  
6 or recipient of assistance under this title unless such applicant or  
7 recipient is such individual's spouse or such individual's child who is  
8 under twenty-one years of age. In determining the eligibility of a child  
9 who is categorically eligible as blind or disabled, as determined under  
10 regulations prescribed by the social security act for medical assist-  
11 ance, the income [and resources] of parents or spouses of parents are  
12 not considered available to that child if she/he does not regularly  
13 share the common household even if the child returns to the common  
14 household for periodic visits. In the application of standards of eligi-  
15 bility with respect to income, costs incurred for medical care, whether  
16 in the form of insurance premiums or otherwise, shall be taken into  
17 account. Any person who is eligible for, or reasonably appears to meet  
18 the criteria of eligibility for, benefits under title XVIII of the  
19 federal social security act shall be required to apply for and fully  
20 utilize such benefits in accordance with this chapter.

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

27 (i) In the case of a revocable trust created by an applicant or recip-  
28 ient, as determined pursuant to regulations of the department[: the

1 trust corpus must be considered to be an available resource;] payments  
2 made from the trust to or for the benefit of such applicant or recipient  
3 must be considered to be available income; and any other payments from  
4 the trust must be considered to be assets disposed of by such applicant  
5 or recipient for purposes of paragraph (d) of subdivision five of this  
6 section.

7 (ii) In the case of an irrevocable trust created by an applicant or  
8 recipient, as determined pursuant to regulations of the department: any  
9 portion of the trust corpus, and of the income generated by the trust  
10 corpus, from which no payment can under any circumstances be made to  
11 such applicant or recipient must be considered, as of the date of estab-  
12 lishment of the trust, or, if later, the date on which payment to the  
13 applicant or recipient is foreclosed, to be assets disposed of by such  
14 applicant or recipient for purposes of paragraph (d) of subdivision five  
15 of this section; [any portion of the trust corpus, and of the income  
16 generated by the trust corpus, from which payment could be made to or  
17 for the benefit of such applicant or recipient must be considered to be  
18 an available resource;] payments made from the trust to or for the bene-  
19 fit of such applicant or recipient must be considered to be available  
20 income; and any other payments from the trust must be considered to be  
21 assets disposed of by such applicant or recipient for purposes of para-  
22 graph (d) of subdivision five of this section.

23 (iii) Notwithstanding the provisions of clauses (i) and (ii) of this  
24 subparagraph, in the case of an applicant or recipient who is disabled,  
25 as such term is defined in section 1614(a)(3) of the federal social  
26 security act, the department must not consider as available income [or  
27 resources] the [corpus or] income of the following trusts which comply  
28 with the provisions of the regulations authorized by clause (iv) of this

1 subparagraph: (A) a trust containing the assets of such a disabled indi-  
2 vidual which was established for the benefit of the disabled individual  
3 while such individual was under sixty-five years of age by the individ-  
4 ual, a parent, grandparent, legal guardian, or court of competent juris-  
5 diction, if upon the death of such individual the state will receive all  
6 amounts remaining in the trust up to the total value of all medical  
7 assistance paid on behalf of such individual; (B) and a trust containing  
8 the assets of such a disabled individual established and managed by a  
9 non-profit association which maintains separate accounts for the benefit  
10 of disabled individuals, but, for purposes of investment and management  
11 of trust funds, pools the accounts, provided that accounts in the trust  
12 fund are established solely for the benefit of individuals who are disa-  
13 bled as such term is defined in section 1614(a)(3) of the federal social  
14 security act by such disabled individual, a parent, grandparent, legal  
15 guardian, or court of competent jurisdiction, and to the extent that  
16 amounts remaining in the individual's account are not retained by the  
17 trust upon the death of the individual, the state will receive all such  
18 remaining amounts up to the total value of all medical assistance paid  
19 on behalf of such individual. Notwithstanding any law to the contrary,  
20 a not-for-profit corporation may, in furtherance of and as an adjunct to  
21 its corporate purposes, act as trustee of a trust for persons with disa-  
22 bilities established pursuant to this subclause, provided that a trust  
23 company, as defined in subdivision seven of section one hundred-c of the  
24 banking law, acts as co-trustee.

25 (iv) The department shall promulgate such regulations as may be neces-  
26 sary to carry out the provisions of this subparagraph. Such regulations  
27 shall include provisions for: assuring the fulfillment of fiduciary  
28 obligations of the trustee with respect to the remainder interest of the

1 department or state; monitoring pooled trusts; applying this subdivision  
2 to legal instruments and other devices similar to trusts, in accordance  
3 with applicable federal rules and regulations; and establishing proce-  
4 dures under which the application of this subdivision will be waived  
5 with respect to an applicant or recipient who demonstrates that such  
6 application would work an undue hardship on him or her, in accordance  
7 with standards specified by the secretary of the federal department of  
8 health and human services. Such regulations may require: notification of  
9 the department of the creation or funding of such a trust for the bene-  
10 fit of an applicant for or recipient of medical assistance; notification  
11 of the department of the death of a beneficiary of such a trust who is a  
12 current or former recipient of medical assistance; in the case of a  
13 trust, the corpus of which exceeds one hundred thousand dollars, notifi-  
14 cation of the department of transactions tending to substantially  
15 deplete the trust corpus; notification of the department of any trans-  
16 actions involving transfers from the trust corpus for less than fair  
17 market value; the bonding of the trustee when the assets of such a trust  
18 equal or exceed one million dollars, unless a court of competent juris-  
19 diction waives such requirement; and the bonding of the trustee when the  
20 assets of such a trust are less than one million dollars, upon order of  
21 a court of competent jurisdiction. The department, together with the  
22 department of financial services, shall promulgate regulations governing  
23 the establishment, management and monitoring of trusts established  
24 pursuant to subclause (B) of clause (iii) of this subparagraph in which  
25 a not-for-profit corporation and a trust company serve as co-trustees.

26 (v) Notwithstanding any acts, omissions or failures to act of a trus-  
27 tee of a trust which the department or a local social services official  
28 has determined complies with the provisions of clause (iii) and the



1 regulations authorized by clause (iv) of this subparagraph, the depart-  
2 ment must not consider the [corpus or] income of any such trust as  
3 available income [or resources] of the applicant or recipient who is  
4 disabled, as such term is defined in section 1614(a)(3) of the federal  
5 social security act. The department's remedy for redress of any acts,  
6 omissions or failures to act by such a trustee which acts, omissions or  
7 failures are considered by the department to be inconsistent with the  
8 terms of the trust, contrary to applicable laws and regulations of the  
9 department, or contrary to the fiduciary obligations of the trustee  
10 shall be the commencement of an action or proceeding under subdivision  
11 one of section sixty-three of the executive law to safeguard or enforce  
12 the state's remainder interest in the trust, or such other action or  
13 proceeding as may be lawful and appropriate as to assure compliance by  
14 the trustee or to safeguard and enforce the state's remainder interest  
15 in the trust.

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

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

4 (a) Medical assistance shall be furnished to applicants in cases  
5 where, although such applicant has a responsible relative with suffi-  
6 cient income [and resources] to provide medical assistance as determined  
7 by the regulations of the department, the income [and resources] of the  
8 responsible relative are not available to such applicant because of the  
9 absence of such relative or the refusal or failure of such relative to  
10 provide the necessary care and assistance. In such cases, however, the  
11 furnishing of such assistance shall create an implied contract with such  
12 relative, and the cost thereof may be recovered from such relative in  
13 accordance with title six of article three of this chapter and other  
14 applicable provisions of law.

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

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

24 § 9. Subparagraph (vii) of paragraph (b) of subdivision 7 of section  
25 366 of the social services law, as amended by chapter 324 of the laws of  
26 2004, is amended to read as follows:

27 (vii) be ineligible for medical assistance because the income [and  
28 resources] of responsible relatives are deemed available to him or her,

1 causing him or her to exceed the income or resource eligibility level  
2 for such assistance;

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

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

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

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

21 § 12. Subparagraph (vi) of paragraph (b) of subdivision 9 of section  
22 366 of the social services law, as added by chapter 170 of the laws of  
23 1994, is amended to read as follows:

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

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

4 k. Notwithstanding any provision of this chapter other than subdivi-  
5 sion six or seven of this section, or any other law to the contrary, for  
6 purposes of determining medical assistance eligibility for persons spec-  
7 ified in paragraphs b and c of this subdivision, the income [and  
8 resources] of a responsible relative shall not be deemed available for  
9 as long as the person meets the criteria specified in this subdivision.

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

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

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

26 § 16. Paragraph (c) of subdivision 2 of section 366-a of the social  
27 services law, as added by section 29 of part B of section 58 of the laws

1 of 2010 and as relettered by section fifteen of this act, is amended to  
2 read as follows:

3 (c) Notwithstanding the provisions of paragraph (a) of this subdivi-  
4 sion, an applicant or recipient [whose eligibility under this title is  
5 determined without regard to the amount of his or her accumulated  
6 resources] may attest to the amount of interest income generated by  
7 [such] resources if the amount of such interest income is expected to be  
8 immaterial to medical assistance eligibility, as determined by the  
9 commissioner of health. In the event there is an inconsistency between  
10 the information reported by the applicant or recipient and any informa-  
11 tion obtained by the commissioner of health from other sources and such  
12 inconsistency is material to medical assistance eligibility, the commis-  
13 sioner of health shall request that the applicant or recipient provide  
14 adequate documentation to verify [his or her] their interest income.

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

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

20 (a) Notwithstanding subdivisions two and five of this section, infor-  
21 mation concerning income [and resources] of applicants for and recipi-  
22 ents of medical assistance may be verified by matching client informa-  
23 tion with information contained in the wage reporting system established  
24 by section one hundred seventy-one-a of the tax law and in similar  
25 systems operating in other geographically contiguous states, by means of  
26 an income verification performed pursuant to a memorandum of understand-  
27 ing with the department of taxation and finance pursuant to subdivision  
28 four of section one hundred seventy-one-b of the tax law, and, to the

1 extent required by federal law, with information contained in the non-  
2 wage income file maintained by the United States internal revenue  
3 service, in the beneficiary data exchange maintained by the United  
4 States department of health and human services, and in the unemployment  
5 insurance benefits file. Such matching shall provide for procedures  
6 which document significant inconsistent results of matching activities.  
7 Nothing in this section shall be construed to prohibit activities the  
8 department reasonably believes necessary to conform with federal  
9 requirements under section one thousand one hundred thirty-seven of the  
10 social security act.

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

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

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

22 § 21. Subdivisions 5 and 6 of section 366-c of the social services law  
23 are REPEALED and subdivisions 7 and 8 are renumbered subdivisions 5 and  
24 6.

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

1 5. (a) At the beginning or after the commencement of a continuous  
2 period of institutionalization, either spouse may request [an assessment  
3 of the total value of their resources or] a determination of the commu-  
4 nity spouse monthly income allowance, the amount of the family allow-  
5 ance, or the method of computing the amount of the family allowance, or  
6 the method of computing the amount of the community spouse income allow-  
7 ance.

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

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

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

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

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

16 [(c) If either spouse establishes that income generated by the commu-  
17 nity spouse resource allowance, established by the social services  
18 district, is inadequate to raise the community spouse's income to the  
19 minimum monthly maintenance needs allowance, the department shall estab-  
20 lish a resource allowance for the spousal share of the institutionalized  
21 spouse adequate to provide such minimum monthly maintenance needs allow-  
22 ance.]

23 § 23. The commissioner of health shall, consistent with the social  
24 services law, make any necessary amendments to the state plan for  
25 medical assistance submitted pursuant to section three hundred sixty-  
26 three of the social services law, in order to ensure federal financial  
27 participation in expenditures under the provisions of this act. The  
28 provisions of this act shall not take effect unless all necessary



1 approvals under federal law and regulation have been obtained to receive  
2 federal financial participation for the costs of services provide here-  
3 under.

4 § 24. This act shall take effect January 1, 2023, subject to federal  
5 financial participation; provided, however that the amendments to para-  
6 graph h of subdivision 6 of section 366 of the social services law made  
7 by section eight of this act shall not affect the repeal of such subdi-  
8 vision and shall be deemed repealed therewith; provided further that the  
9 commissioner of health shall notify the legislative bill drafting  
10 commission upon the occurrence of federal financial participation in  
11 order that the commission may maintain an accurate and timely effective  
12 data base of the official text of the laws of the state of New York in  
13 furtherance of effectuating the provisions of section 44 of the legisla-  
14 tive law and section 70-b of the public officers law.

15 PART O

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

19 3. Provider directory for fee-for-service private duty nursing  
20 services provided to medically fragile children and adults. The commis-  
21 sioner of health is authorized to establish a directory of qualified  
22 providers for the purpose of promoting the availability and ensuring  
23 delivery of fee-for-service private duty nursing services to medically  
24 fragile children and individuals transitioning out of such category of  
25 care, and medically fragile adults. Qualified providers enrolling in  
26 the directory shall ensure the availability and delivery of and shall

1 provide such services to those individuals as are in need of such  
2 services, and shall receive increased reimbursement for such services  
3 pursuant to paragraph (c) of subdivision two, and paragraph (c) of  
4 subdivision four of this section. The directory shall offer enrollment  
5 to all private duty nursing services providers to promote and ensure the  
6 participation in the directory of all nursing services providers avail-  
7 able to serve medically fragile children and adults.

8 4. Medically fragile adults. (a) The commissioner shall increase rates  
9 for private duty nursing services that are provided to medically fragile  
10 adults, as such term is defined by the commissioner in regulation, to  
11 ensure the availability of such services to such adults. In establish-  
12 ing rates of payment under this subdivision, the commissioner shall  
13 consider the cost neutrality of such rates as related to the cost effec-  
14 tiveness of caring for medically fragile adults in a non-institutional  
15 setting as compared to an institutional setting. Such increased rates  
16 for services rendered to such adults may take into consideration the  
17 elements of cost, geographical differentials in the elements of cost  
18 considered, economic factors in the area in which the private duty nurs-  
19 ing service is provided, costs associated with the provision of private  
20 duty nursing services to medically fragile adults, and the need for  
21 incentives to improve services and institute economies and such  
22 increased rates shall be payable only to those private duty nurses who  
23 can demonstrate, to the satisfaction of the department of health, satis-  
24 factory training and experience to provide services to such adults. Such  
25 increased rates shall be determined based on application of the case mix  
26 adjustment factor for AIDS home care program services rates as deter-  
27 mined pursuant to applicable regulations of the department of health.

1 The commissioner may promulgate regulations to implement the provisions  
2 of this subdivision.

3 (b) Private duty nursing services providers which have their rates  
4 adjusted pursuant to paragraph (a) of this subdivision shall use such  
5 funds solely for the purposes of recruitment and retention of private  
6 duty nurses or to ensure the delivery of private duty nursing services  
7 to medically fragile adults and are prohibited from using such funds for  
8 any other purpose. Funds provided under paragraph (a) of this subdivi-  
9 sion are not intended to supplant support provided by a local govern-  
10 ment. Each such provider, with the exception of self-employed private  
11 duty nurses, shall submit, at a time and in a manner to be determined by  
12 the commissioner of health, a written certification attesting that such  
13 funds will be used solely for the purpose of recruitment and retention  
14 of private duty nurses or to ensure the delivery of private duty nursing  
15 services to medically fragile adults. The commissioner of health and  
16 their designees are authorized to audit each such provider to ensure  
17 compliance with the written certification required by this subdivision  
18 and shall recoup all funds determined to have been used for purposes  
19 other than recruitment and retention of private duty nurses or the  
20 delivery of private duty nursing services to medically fragile adults.  
21 Such recoupment shall be in addition to any other penalties provided by  
22 law.

23 (c) The commissioner of health shall, subject to the provisions of  
24 paragraph (b) of this subdivision, and the provisions of subdivision  
25 three of this section, and subject to the availability of federal finan-  
26 cial participation, increase fees for the fee-for-service reimbursement  
27 of private duty nursing services provided to medically fragile adults by  
28 fee-for-service private duty nursing services providers who enroll and

1 participate in the provider directory pursuant to subdivision three of  
2 this section, commencing April first, two thousand twenty-two, such that  
3 such fees for reimbursement equal the final benchmark payment designed  
4 to ensure adequate access to the service. In developing such benchmark  
5 the commissioner of health may utilize the average two thousand eighteen  
6 Medicaid managed care payments for reimbursement of such private duty  
7 nursing services. The commissioner may promulgate regulations to imple-  
8 ment the provisions of this paragraph.

9 § 2. Section 21 of part MM of chapter 56 of the laws of 2020, direct-  
10 ing the department of health to establish or procure the services of  
11 an independent panel of clinical professionals and to develop and imple-  
12 ment a uniform task-based assessment tool, is amended to read as  
13 follows:

14 § 21. The department of health shall develop[, directly or through  
15 procurement, and shall implement an evidenced based validated uniform  
16 task-based assessment tool no later than April 1, 2021,] guidelines and  
17 standards for the use of tasking tools to assist managed care plans and  
18 local departments of social services to make appropriate and individual-  
19 ized determinations for utilization of home care services in accordance  
20 with applicable state and federal law and regulations, including the  
21 number of personal care services and consumer directed personal assist-  
22 ance hours of care each day[, ] provided pursuant to the state's medical  
23 assistance program, and how Medicaid recipients' needs for assistance  
24 with activities of daily living can be met, such as through telehealth,  
25 provided that services rendered via telehealth meet equivalent quality  
26 and safety standards of services provided through non-electronic means,  
27 and other available alternatives, including family and social supports.  
28 [Notwithstanding the provisions of section 163 of the state finance law,

1 or sections 142 and 143 of the economic development law, or any contrary  
2 provision of law, a contract may be entered without a competitive bid or  
3 request for proposal process if such contract is for the purpose of  
4 developing the evidence based validated uniform task-based assessment  
5 tool described in this section, provided that:

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

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

10 (ii) The criteria for contractor selection;

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

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

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

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

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

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

1 ARTICLE 29-EE

2 PROGRAMS OF ALL-INCLUSIVE

3 CARE FOR THE ELDERLY

4 Section 2999-s. Definitions.

5 2999-t. PACE organization establishment.

6 2999-u. Criteria for program eligibility and licensure.

7 2999-v. Eligibility and enrollment.

8 2999-w. Included program benefits.

9 2999-x. Reimbursement.

10 § 2999-s. Definitions. For the purposes of this article, the following  
11 terms shall have the following meanings:

12 1. "PACE organization" means a PACE provider, as defined in 42 U.S.C.  
13 § 1395(eee), established in accordance with federal public law 105-33,  
14 subtitle I of title IV of the Balanced Budget Act of 1997, including  
15 amendments thereto.

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

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

23 § 2999-t. PACE organization establishment. 1. Notwithstanding any  
24 inconsistent provision to the contrary, the commissioner shall establish  
25 a program for all-inclusive care for the elderly in New York, to provide  
26 community-based, risk-based, and capitated long-term care services as  
27 optional services under the state's Medicaid state plan and any applica-  
28 ble waivers, as well as under contracts entered into between the federal

1 centers for Medicare and Medicaid services, the department, and PACE  
2 organizations.

3 2. The establishment of such a program shall not preclude the contin-  
4 ued operation of existing approved PACE organizations at the time of  
5 enactment or implementation of this article. The department may estab-  
6 lish a process, if deemed necessary, to assist the transition of such  
7 existing programs through processes and requirements set forth pursuant  
8 to this article.

9 § 2999-u. Criteria for program eligibility and licensure. 1. Program  
10 criteria. The requirements of the PACE model, as provided for pursuant  
11 to 42 U.S.C. § 1395(eee) and 42 U.S.C. § 1396(u-4), including amendments  
12 thereto, shall not be waived or modified. New York state PACE organiza-  
13 tion requirements shall include, but not be limited to:

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

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

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

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

1 (c) PACE organizations shall contract with the federal centers for  
2 Medicare and Medicaid services to enter into a PACE organization agree-  
3 ment.

4 3. Licensure. (a) In setting forth requirements to establish the  
5 state's PACE organization, the department shall provide for a unified  
6 licensure process for PACE organizations that is inclusive of program  
7 requirements set forth under articles twenty-eight, thirty-six, and  
8 forty-four of this chapter, as well as pertinent regulatory requirements  
9 for PACE organizations in accordance with a regulatory approach which  
10 shall be established by the department.

11 (b) An entity may not operate a PACE organization in the state without  
12 being licensed in accordance with this subdivision and any regulations  
13 promulgated hereunder; provided, however, that this requirement shall  
14 not be construed to disallow the operation of approved PACE organiza-  
15 tions at the time of enactment or implementation of this act in accord-  
16 ance with any process established by the department to assist the tran-  
17 sition of such existing programs through processes and requirements set  
18 forth in accordance with this article.

19 4. Operations and oversight. The department shall:

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

25 (b) Provide oversight of PACE organization operations in coordination  
26 with the centers for Medicare and Medicaid services, including the  
27 establishment of any rules appropriate for the safe, efficient and



1 orderly administration of the program and for the maintenance or revoca-  
2 tion of licensure under this article.

3 § 2999-v. Eligibility and enrollment. 1. To be eligible for enrollment  
4 in a PACE organization, an individual must:

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

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

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

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

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

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

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

24 § 2999-w. Included program benefits. Enrollees in all PACE organiza-  
25 tions shall be provided a benefit package, regardless of source of  
26 payment, that includes:

27 1. All Medicare-covered items and services;

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

4 3. Other such services as determined necessary by the interdiscipli-  
5 nary team to improve and maintain the participant's overall health  
6 status.

7 § 2999-x. Reimbursement. The department shall develop and implement,  
8 in conformance with applicable federal requirements, a methodology for  
9 establishing rates of payment for costs of benefits provided by PACE  
10 organizations to its Medicaid eligible enrollees.

11 § 4. This act shall take effect immediately; provided, however, that  
12 section three of this act shall take effect upon the adoption of rules  
13 and regulations by the commissioner of health governing the licensure of  
14 PACE organizations as provided under article 29-EE of the public health  
15 law as added by section three of this act; provided that the commission-  
16 er of health shall notify the legislative bill drafting commission upon  
17 the occurrence of the adoption of rules and regulations pursuant to such  
18 section in order that the commission may maintain an accurate and timely  
19 effective data base of the official text of the laws of the state of New  
20 York in furtherance of effectuating the provisions of section 44 of the  
21 legislative law and section 70-b of the public officers law. Effective  
22 immediately, the addition, amendment and/or repeal of any rule or regu-  
23 lation necessary for the implementation of this act on its effective  
24 date are authorized to be made and completed on or before such effective  
25 date.

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

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

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

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

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

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

21 (v) applications demonstrating to the commissioner of health's satis-  
22 faction that submission of the application for consideration would be  
23 appropriate to address a serious concern with care delivery, such as a  
24 lack of adequate access to managed care providers in a geographic area  
25 or a lack of adequate and appropriate care, language and cultural compe-  
26 tence, or special needs services.

27 § 2. Subdivision 5 of section 364-j of the social services law, as  
28 amended by section 15 of part C of chapter 58 of the laws of 2004, para-

1 graph (a) as amended by section 40 of part A of chapter 56 of the laws  
2 of 2013, paragraphs (d), (e) and (f) as amended by section 80 of part H  
3 of chapter 59 of the laws of 2011, is amended to read as follows:

4 5. Managed care programs shall be conducted in accordance with the  
5 requirements of this section and, to the extent practicable, encourage  
6 the provision of comprehensive medical services, pursuant to this arti-  
7 cle.

8 (a) The managed care program notwithstanding sections one hundred  
9 twelve and one hundred sixty-three of the state finance law, sections  
10 one hundred forty-two and one hundred forty-three of the economic devel-  
11 opment law, and any other inconsistent provision of law, the commission-  
12 er of health shall, through a competitive bid process based on proposals  
13 submitted to the department, provide for the selection of qualified  
14 managed care providers [by the commissioner of health] to participate in  
15 the managed care program pursuant to a contract with the department,  
16 including [comprehensive HIV special needs plans and] special needs  
17 managed care plans in accordance with the provisions of section three  
18 hundred sixty-five-m of this title; provided, however, that the commis-  
19 sioner of health may contract directly with comprehensive HIV special  
20 needs plans [consistent with standards set forth in this section] with-  
21 out a competitive bid process, and assure that such providers are acces-  
22 sible taking into account the needs of persons with disabilities and the  
23 differences between rural, suburban, and urban settings, and in suffi-  
24 cient numbers to meet the health care needs of participants, and shall  
25 consider the extent to which major public hospitals are included within  
26 such providers' networks[.

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

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

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

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

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

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

14 [(v)] (E) demonstrate the applicant's ability to meet the data analy-  
15 sis and reporting requirements of the program;

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

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

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

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

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

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

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

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

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

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

13 (H) whether the bidder participates in value based payment arrange-  
14 ments as defined by the department, including the delegation of signif-  
15 icant financial risk to clinically integrated provider networks;

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

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

19 (K) the bidder's commitment to community reinvestment spending, as  
20 shall be defined in the procurement;

21 (L) for current or previously authorized managed care providers, past  
22 performance in meeting managed care contract or federal or state  
23 requirements, and if the commissioner issued any statements of findings,  
24 statements of deficiency, intermediate sanctions or enforcement actions  
25 to a bidder for non-compliance with such requirements, whether the  
26 bidder addressed such issues in a timely manner;

27 (M) such criteria as the commissioner of health shall develop, with  
28 the commissioners of the office of mental health, the office for people

1 with developmental disabilities, the office of addiction services and  
2 supports, and the office of children and family services, as applicable;  
3 and

4 (N) any other criteria deemed appropriate by the commissioner of  
5 health.

6 (iii) Subparagraphs (i) and (ii) of this paragraph describing proposal  
7 content and selection criteria requirements shall not be construed as  
8 limiting or requiring the commissioner of health to evaluate such  
9 content or criteria on a pass-fail, scale, or other methodological  
10 basis; provided however, that the commissioner shall consider all such  
11 content and criteria using methods determined by the commissioner of  
12 health in their discretion and, as applicable, in consultation with the  
13 commissioners of the office of mental health, the office for people with  
14 developmental disabilities, the office of addiction services and  
15 supports, and the office of children and family services.

16 (iv) The department of health shall post on its website:

17 (A) The request for proposals and a description of the proposed  
18 services to be provided pursuant to contracts in accordance with this  
19 subdivision;

20 (B) The criteria on which the department shall determine qualified  
21 bidders and evaluate their proposals, including all criteria identified  
22 in this subdivision;

23 (C) The manner by which a proposal may be submitted, which may include  
24 submission by electronic means;

25 (D) The manner by which a managed care provider may continue to  
26 participate in the managed care program pending award of managed care  
27 providers through a competitive bid process pursuant to this subdivi-  
28 sion; and

1 (E) Upon award, the managed care providers that the commissioner  
2 intends to contract with pursuant to this subdivision, provided that the  
3 commissioner shall update such list to indicate the final slate of  
4 contracted managed care providers.

5 (v)(A) All responsive submissions that are received from bidders in a  
6 timely fashion shall be reviewed by the commissioner of health in  
7 consultation with the commissioners of the office of mental health, the  
8 office for people with developmental disabilities, the office of  
9 addiction services and supports, and the office of children and family  
10 services, as applicable. The commissioner shall consider comments  
11 resulting from the review of proposals and make awards in consultation  
12 with such agencies.

13 (B) The commissioner of health shall make awards under this subdivi-  
14 sion for each product, for which proposals were requested, to at least  
15 two managed care providers in each geographic region defined by the  
16 commissioner in the request for proposals for which at least two managed  
17 care providers have submitted a proposal, and shall have discretion to  
18 offer more contracts based on need for access; provided, however, that  
19 the commissioner of health shall not offer any more than five (5)  
20 contracts in any one region.

21 (C) Managed care providers awarded under this subdivision shall be  
22 entitled to enter into a contract with the department for the purpose of  
23 participating in the managed care program. Such contracts shall run for  
24 a term to be determined by the commissioner, which may be renewed or  
25 modified from time to time without a new request for proposals, to  
26 ensure consistency with changes in federal and state laws, regulations  
27 or policies, including but not limited to the expansion or reduction of



1 medical assistance services available to participants through a managed  
2 care provider.

3 (D) Nothing in this paragraph or other provision of this section shall  
4 be construed to limit in any way the ability of the department of health  
5 to terminate awarded contracts for cause, which shall include but not be  
6 limited to any violation of the terms of such contracts or violations of  
7 state or federal laws and regulations and any loss of necessary state or  
8 federal funding.

9 (E) Notwithstanding sections one hundred twelve and one hundred  
10 sixty-three of the state finance law, sections one hundred forty-two and  
11 one hundred forty-three of the economic development law, and any other  
12 inconsistent provision of law, the department of health may, in accord-  
13 ance with the provisions of this paragraph, issue new requests for  
14 proposals and award new contracts for terms following an existing term  
15 of a contract entered into under this paragraph.

16 (b)(i) Within sixty days of the department of health issuing the  
17 request for proposals under paragraph (a) of this subdivision, a managed  
18 care provider that was approved to participate in the managed care  
19 program prior to the issuance of the request for proposals, shall submit  
20 its intention to complete such proposal to the department.

21 (ii) A managed care provider that: (A) fails to submit its intent  
22 timely, (B) indicates within the sixty-days its intent not to complete  
23 such a proposal, (C) fails to submit a proposal within the further time-  
24 frame specified by the commissioner of health in the request for  
25 proposals, or (D) is not awarded the ability to participate in the  
26 managed care program under paragraph (a) of this subdivision, shall,  
27 upon direction from the commissioner of health, terminate its services  
28 and operations in accordance with the contract between the managed care

1 provider and the department of health and shall be additionally required  
2 to maintain coverage of participants for such period of time as deter-  
3 mined necessary by the commissioner of health to achieve the safe and  
4 orderly transfer of participants.

5 (c) [The commissioner of health shall make a determination whether to  
6 approve, disapprove or recommend modification of the proposal] If neces-  
7 sary to ensure access to sufficient number of managed care providers on  
8 a geographic or other basis, including a lack of adequate and appropri-  
9 ate care, language and cultural competence, or special needs services,  
10 the commissioner of health may reissue a request for proposals as  
11 provided for under paragraph (a) of this subdivision, provided however,  
12 that such request may be limited to the geographic or other basis of  
13 need that the request for proposals is seeking to address. Any awards  
14 made shall be subject to the requirements of this section, including but  
15 not limited to the minimum and maximum number of awards in a region.

16 (d) [Notwithstanding any inconsistent provision of this title and  
17 section one hundred sixty-three of the state finance law, the commis-  
18 sioner of health may contract with managed care providers approved under  
19 paragraph (b) of this subdivision, without a competitive bid or request  
20 for proposal process, to provide coverage for participants pursuant to  
21 this title.

22 (e) Notwithstanding any inconsistent provision of this title and  
23 section one hundred forty-three of the economic development law, no  
24 notice in the procurement opportunities newsletter shall be required for  
25 contracts awarded by the commissioner of health, to qualified managed  
26 care providers pursuant to this section.

27 (f)] The care and services described in subdivision four of this  
28 section will be furnished by a managed care provider pursuant to the

1 provisions of this section when such services are furnished in accord-  
2 ance with an agreement with the department of health, and meet applica-  
3 ble federal law and regulations.

4 [(g)] (e) The commissioner of health may delegate some or all of the  
5 tasks identified in this section to the local districts.

6 [(h)] (f) Any delegation pursuant to paragraph [(g)] (e) of this  
7 subdivision shall be reflected in the contract between a managed care  
8 provider and the commissioner of health.

9 § 3. Subdivision 4 of section 365-m of the social services law is  
10 REPEALED and a new subdivision 4 is added to read as follows:

11 4. The commissioner of health, jointly with the commissioners of the  
12 office of mental health and the office of addiction services and  
13 supports, shall select a limited number of special needs managed care  
14 plans under section three hundred sixty-four-j of this title, in accord-  
15 ance with subdivision five of such section, capable of managing the  
16 behavioral and physical health needs of medical assistance enrollees  
17 with significant behavioral health needs.

18 § 4. The opening paragraph of subdivision 2 of section 4403-f of the  
19 public health law, as amended by section 8 of part C of chapter 58 of  
20 the laws of 2007, is amended to read as follows:

21 An eligible applicant shall submit an application for a certificate of  
22 authority to operate a managed long term care plan upon forms prescribed  
23 by the commissioner, including any such forms or process as may be  
24 required or prescribed by the commissioner in accordance with the  
25 competitive bid process under subdivision six of this section. Such  
26 eligible applicant shall submit information and documentation to the  
27 commissioner which shall include, but not be limited to:

1 § 5. Subdivision 3 of section 4403-f of the public health law, as  
2 amended by section 41-a of part H of chapter 59 of the laws of 2011, is  
3 amended to read as follows:

4 3. Certificate of authority; approval. (a) The commissioner shall not  
5 approve an application for a certificate of authority unless the appli-  
6 cant demonstrates to the commissioner's satisfaction:

7 [(a)] (i) that it will have in place acceptable quality-assurance  
8 mechanisms, grievance procedures, mechanisms to protect the rights of  
9 enrollees and case management services to ensure continuity, quality,  
10 appropriateness and coordination of care;

11 [(b)] (ii) that it will include an enrollment process which shall  
12 ensure that enrollment in the plan is informed. The application shall  
13 describe the disenrollment process, which shall provide that an other-  
14 wise eligible enrollee shall not be involuntarily disenrolled on the  
15 basis of health status;

16 [(c)] (iii) satisfactory evidence of the character and competence of  
17 the proposed operators and reasonable assurance that the applicant will  
18 provide high quality services to an enrolled population;

19 [(d)] (iv) sufficient management systems capacity to meet the require-  
20 ments of this section and the ability to efficiently process payment for  
21 covered services;

22 [(e)] (v) readiness and capability to maximize reimbursement of and  
23 coordinate services reimbursed pursuant to title XVIII of the federal  
24 social security act and all other applicable benefits, with such benefit  
25 coordination including, but not limited to, measures to support sound  
26 clinical decisions, reduce administrative complexity, coordinate access  
27 to services, maximize benefits available pursuant to such title and  
28 ensure that necessary care is provided;

1 [(f)] (vi) readiness and capability to arrange and manage covered  
2 services and coordinate non-covered services which could include prima-  
3 ry, specialty, and acute care services reimbursed pursuant to title XIX  
4 of the federal social security act;

5 [(g)] (vii) willingness and capability of taking, or cooperating in,  
6 all steps necessary to secure and integrate any potential sources of  
7 funding for services provided by the managed long term care plan,  
8 including, but not limited to, funding available under titles XVI,  
9 XVIII, XIX and XX of the federal social security act, the federal older  
10 Americans act of nineteen hundred sixty-five, as amended, or any succes-  
11 sor provisions subject to approval of the director of the state office  
12 for aging, and through financing options such as those authorized pursu-  
13 ant to section three hundred sixty-seven-f of the social services law;

14 [(h)] (viii) that the contractual arrangements for providers of health  
15 and long term care services in the benefit package are sufficient to  
16 ensure the availability and accessibility of such services to the  
17 proposed enrolled population consistent with guidelines established by  
18 the commissioner; with respect to individuals in receipt of such  
19 services prior to enrollment, such guidelines shall require the managed  
20 long term care plan to contract with agencies currently providing such  
21 services, in order to promote continuity of care. In addition, such  
22 guidelines shall require managed long term care plans to offer and cover  
23 consumer directed personal assistance services for eligible individuals  
24 who elect such services pursuant to section three hundred sixty-five-f  
25 of the social services law; and

26 [(i)] (ix) that the applicant is financially responsible and may be  
27 expected to meet its obligations to its enrolled members.

1 (b) Notwithstanding the provisions of paragraph (a) of this subdivi-  
2 sion, the approval of any application for certification as a managed  
3 long term care plan under this section for a plan that seeks to cover a  
4 population of enrollees eligible for services under title XIX of the  
5 federal social security act, shall be subject to and conditioned on  
6 selection through the competitive bid process provided under subdivision  
7 six of this section.

8 § 6. Subdivision 6 of section 4403-f of the public health law, as  
9 amended by section 41-b of part H of chapter 59 of the laws of 2011,  
10 paragraph (a) as amended by section 4 and paragraphs (d), (e) and (f) as  
11 added by section 5 of part MM of chapter 56 of the laws of 2020, is  
12 amended to read as follows:

13 6. Approval authority. [(a)] An applicant shall be issued a certif-  
14 icate of authority as a managed long term care plan upon a determination  
15 by the commissioner that the applicant complies with the operating  
16 requirements for a managed long term care plan under this section;  
17 provided, however, that any managed long term care plan seeking to  
18 provide health and long term care services to a population of enrollees  
19 that are eligible under title XIX of the federal social security act  
20 shall not receive a certificate of authority, nor be eligible for a  
21 contract to provide such services with the department, unless selected  
22 through the competitive bid process described in this subdivision. [The  
23 commissioner shall issue no more than seventy-five certificates of  
24 authority to managed long term care plans pursuant to this section.  
25 Nothing in this section shall be construed as requiring the department  
26 to contract with or to contract for a particular line of business with  
27 an entity certified under this section for the provision of services  
28 available under title eleven of article five of the social services law.

1 (b) An operating demonstration shall be issued a certificate of  
2 authority as a managed long term care plan upon a determination by the  
3 commissioner that such demonstration complies with the operating  
4 requirements for a managed long term care plan under this section.  
5 Nothing in this section shall be construed to affect the continued legal  
6 authority of an operating demonstration to operate its previously  
7 approved program.

8 (c) For the period beginning April first, two thousand twelve and  
9 ending March thirty-first, two thousand fifteen, the majority leader of  
10 the senate and the speaker of the assembly may each recommend to the  
11 commissioner, in writing, up to four eligible applicants to convert to  
12 be approved managed long term care plans. An applicant shall only be  
13 approved and issued a certificate of authority if the commissioner  
14 determines that the applicant meets the requirements of subdivision  
15 three of this section. The majority leader of the senate or the speaker  
16 of the assembly may assign their authority to recommend one or more  
17 applicants under this section to the commissioner.]

18 (a) Notwithstanding sections one hundred twelve and one hundred  
19 sixty-three of the state finance law, sections one hundred forty-two and  
20 one hundred forty-three of the economic development law, and any other  
21 inconsistent provision of law, the commissioner of health shall, through  
22 a competitive bid process based on proposals submitted to the depart-  
23 ment, provide for the selection of qualified managed long term care  
24 plans to provide health and long term care services to enrollees who are  
25 eligible under title XIX of the federal social security act pursuant to  
26 a contract with the department; provided, however, that:

27 (i) A proposal submitted by a managed long term care plan shall  
28 include information sufficient to allow the commissioner to evaluate the

1 bidder in accordance with the requirements identified in subdivisions  
2 two through four of this section.

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

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

8 (B) the extent to which major public hospitals are included in the  
9 submitted provider network, if applicable;

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

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

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

15 (F) the type and number of products the bidder proposes to operate,  
16 including products applied for in accordance with the provisions of  
17 subdivision five of section three hundred sixty-four-j of the social  
18 services law, and other products determined by the commissioner, includ-  
19 ing but not necessarily limited to those operated under title one-A of  
20 article twenty-five of this chapter and section three hundred sixty-  
21 nine-gg of the social services law;

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

24 (H) whether the bidder participates in value based payment arrange-  
25 ments as defined by the department, including the delegation of signif-  
26 icant financial risk to clinically integrated provider networks;

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



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

2 (K) the bidder's commitment to community reinvestment spending, as  
3 shall be defined in the procurement;

4 (L) for current or previously authorized managed care providers, past  
5 performance in meeting managed care contract or federal or state  
6 requirements, and if the commissioner issued any statements of findings,  
7 statements of deficiency, intermediate sanctions or enforcement actions  
8 to a bidder for non-compliance with such requirements, whether the  
9 bidder addressed such issues in a timely manner;

10 (M) such criteria as the commissioner shall develop, with the commis-  
11 sioners of the office of mental health, the office for people with  
12 developmental disabilities, the office of addiction services and  
13 supports, and the office of children and family services; and

14 (N) any other criteria deemed appropriate by the commissioner.

15 (iii) Subparagraphs (i) and (ii) of this paragraph describing proposal  
16 content and selection criteria requirements shall not be construed as  
17 limiting or requiring the commissioner to evaluate such content or  
18 criteria on a pass-fail, scale, or other particular methodological  
19 basis; provided however, that the commissioner must consider all such  
20 content and criteria using methods determined by the commissioner in  
21 their discretion and, as applicable, in consultation with the commis-  
22 sioners of the office of mental health, the office for people with  
23 developmental disabilities, the office of addiction services and  
24 supports, and the office of children and family services.

25 (iv) The department shall post on its website:

26 (A) The request for proposals and a description of the proposed  
27 services to be provided pursuant to contracts in accordance with this  
28 subdivision;

1 (B) The criteria on which the department shall determine qualified  
2 bidders and evaluate their applications, including all criteria identi-  
3 fied in this subdivision;

4 (C) The manner by which a proposal may be submitted, which may include  
5 submission by electronic means;

6 (D) The manner by which a managed long term care plan may continue to  
7 provide health and long term care services to enrollees who are eligible  
8 under title XIX of the federal social security act pending awards to  
9 managed long term care plans through a competitive bid process pursuant  
10 to this subdivision; and

11 (E) Upon award, the managed long term care plans that the commissioner  
12 intends to contract with pursuant to this subdivision, provided that the  
13 commissioner shall update such list to indicate the final slate of  
14 contracted managed long term care plans.

15 (v) (A) All responsive submissions that are received from bidders in a  
16 timely fashion shall be reviewed by the commissioner of health in  
17 consultation with the commissioners of the office of mental health, the  
18 office for people with developmental disabilities, the office of  
19 addiction services and supports, and the office of children and family  
20 services, as applicable. The commissioner shall consider comments  
21 resulting from the review of proposals and make awards in consultation  
22 with such agencies.

23 (B) The commissioner shall make awards under this subdivision, for  
24 each product for which proposals were requested, to at least two managed  
25 long term care plans in each geographic region defined by the commis-  
26 sioner in the request for proposals for which at least two managed long  
27 term care plans have submitted a proposal, and shall have discretion to  
28 offer more contracts based on need for access; provided, however, that

1 the commissioner shall not offer any more than five (5) contracts in any  
2 one region.

3 (C) Managed long term care plans awarded under this subdivision shall  
4 be entitled to enter into a contract with the department for the purpose  
5 of providing health and long term care services to enrollees who are  
6 eligible under title XIX of the federal social security act. Such  
7 contracts shall run for a term to be determined by the commissioner,  
8 which may be renewed or modified from time to time without a new request  
9 for proposals, to ensure consistency with changes in federal and state  
10 laws, regulations or policies, including but not limited to the expan-  
11 sion or reduction of medical assistance services available to partic-  
12 ipants through a managed long term care plan.

13 (D) Nothing in this paragraph or other provision of this section shall  
14 be construed to limit in any way the ability of the department to termi-  
15 nate awarded contracts for cause, which shall include but not be limited  
16 to any violation of the terms of such contracts or violations of state  
17 or federal laws and regulations and any loss of necessary state or  
18 federal funding.

19 (E) Notwithstanding sections one hundred twelve and one hundred  
20 sixty-three of the state finance law, sections one hundred forty-two and  
21 one hundred forty-three of the economic development law, and any other  
22 inconsistent provision of law, the department may, in accordance with  
23 the provisions of this paragraph, issue new requests for proposals and  
24 award new contracts for terms following an existing term of a contract  
25 entered into under this paragraph.

26 (b) (i) Within sixty days of the department issuing the request for  
27 proposals under paragraph (a) of this subdivision, a managed long term  
28 care plan that was approved to provide health and long term care

1 services to enrollees who are eligible under title XIX of the federal  
2 social security act prior to the issuance of the request for proposals,  
3 shall submit its intention to complete such proposal to the department.

4 (ii) A managed long term care plan that: (A) fails to submit its  
5 intent timely, (B) indicates within the sixty days its intent not to  
6 complete such a proposal, (C) fails to submit a proposal within the  
7 further timeframe specified by the commissioner in the request for  
8 proposals, or (D) is not awarded the ability to provide health and long  
9 term care services to enrollees who are eligible under title XIX of the  
10 federal social security act under paragraph (a) of this subdivision,  
11 shall, upon direction from the commissioner, terminate its services and  
12 operations in accordance with the contract between the managed long term  
13 care plan and the department and shall be additionally required to main-  
14 tain coverage of enrollees for such period of time as determined neces-  
15 sary by the commissioner to achieve the safe and orderly transfer of  
16 enrollees.

17 (c) Addressing needs for additional managed long term care plans to  
18 ensure access and choice for enrollees eligible under title XIX of the  
19 federal social security act. If necessary to ensure access to sufficient  
20 number of managed long term care plans on a geographic or other basis,  
21 including a lack of adequate and appropriate care, language and cultural  
22 competence, or special needs services, the commissioner may reissue a  
23 request for proposals as provided for under paragraph (a) of this subdi-  
24 vision, provided however that such request may be limited to the  
25 geographic or other basis of need that the request for proposals seeks  
26 to address. Any awards made shall be subject to the requirements of this  
27 section, including but not limited to the minimum and maximum number of  
28 awards in a region.

1 (d) (i) Effective April first, two thousand twenty, and expiring  
2 [March thirty-first, two thousand twenty-two] on the date the commis-  
3 sioner publishes on its website a request for proposals in accordance  
4 with subparagraph (iv) of paragraph (a) of the subdivision, the commis-  
5 sioner shall place a moratorium on the processing and approval of appli-  
6 cations seeking a certificate of authority as a managed long term care  
7 plan pursuant to this section, including applications seeking authori-  
8 zation to expand an existing managed long term care plan's approved  
9 service area or scope of eligible enrollee populations. Such moratorium  
10 shall not apply to:

11 (A) applications submitted to the department prior to January first,  
12 two thousand twenty;

13 (B) applications seeking approval to transfer ownership or control of  
14 an existing managed long term care plan;

15 (C) applications demonstrating to the commissioner's satisfaction that  
16 submission of the application for consideration would be appropriate to  
17 address a serious concern with care delivery, such as a lack of adequate  
18 access to managed long term care plans in a geographic area or a lack of  
19 adequate and appropriate care, language and cultural competence, or  
20 special needs services; and

21 (D) applications seeking to operate under the PACE (Program of All-In-  
22 clusive Care for the Elderly) model as authorized by federal public law  
23 105-33, subtitle I of title IV of the Balanced Budget Act of 1997, or to  
24 serve individuals dually eligible for services and benefits under titles  
25 XVIII and XIX of the federal social security act in conjunction with an  
26 affiliated Medicare Dual Eligible Special Needs Plan, based on the need  
27 for such plans and the experience of applicants in serving dually eligi-  
28 ble individuals as determined by the commissioner in their discretion.

1 (ii) For the duration of the moratorium, the commissioner shall assess  
2 the public need for managed long term care plans that are not integrated  
3 with an affiliated Medicare plan, the ability of such plans to provide  
4 high quality and cost effective care for their membership, and based on  
5 such assessment develop a process and conduct an orderly wind-down and  
6 elimination of such plans, which shall coincide with the expiration of  
7 the moratorium unless the commissioner determines that a longer wind-  
8 down period is needed.

9 (e) [For the duration of the moratorium under paragraph (d) of this  
10 subdivision] From April first, two thousand twenty, until March thirty-  
11 first, two thousand twenty-two, the commissioner shall establish, and  
12 enforce by means of a premium withholding equal to three percent of the  
13 base rate, an annual cap on total enrollment (enrollment cap) for each  
14 managed long term care plan, subject to subparagraphs (ii) and (iii) of  
15 this paragraph, based on a percentage of each plan's reported enrollment  
16 as of October first, two thousand twenty.

17 (i) The specific percentage of each plan's enrollment cap shall be  
18 established by the commissioner based on: (A) the ability of individuals  
19 eligible for such plans to access health and long term care services,  
20 (B) plan quality of care scores, (C) historical plan disenrollment, (D)  
21 the projected growth of individuals eligible for such plans in different  
22 regions of the state, (E) historical plan enrollment of patients with  
23 varying levels of need and acuity, and (F) other factors in the commis-  
24 sioner's discretion to ensure compliance with federal requirements,  
25 appropriate access to plan services, and choice by eligible individuals.

26 (ii) In the event that a plan exceeds its annual enrollment cap, the  
27 commissioner is authorized under this paragraph to retain all or a  
28 portion of the premium withheld based on the amount over which a plan

1 exceeds its enrollment cap. Penalties assessed pursuant to this subdivi-  
2 sion shall be determined by regulation.

3 (iii) The commissioner may not establish an annual cap on total  
4 enrollment under this paragraph for plans' lines of business operating  
5 under the PACE (Program of All-Inclusive Care for the Elderly) model as  
6 authorized by federal public law 105-33, subtitle I of title IV of the  
7 Balanced Budget Act of 1997, or that serve individuals dually eligible  
8 for services and benefits under titles XVIII and XIX of the federal  
9 social security act in conjunction with an affiliated Medicare Dual  
10 Eligible Special Needs Plan.

11 [(f) In implementing the provisions of paragraphs (d) and (e) of this  
12 subdivision, the commissioner shall, to the extent practicable, consider  
13 and select methodologies that seek to maximize continuity of care and  
14 minimize disruption to the provider labor workforce, and shall, to the  
15 extent practicable and consistent with the ratios set forth herein,  
16 continue to support contracts between managed long term care plans and  
17 licensed home care services agencies that are based on a commitment to  
18 quality and value.]

19 § 7. Subparagraphs (v) and (vi) of paragraph (b) of subdivision 1 of  
20 section 268-d of the public health law, as added by section 2 of part T  
21 of chapter 57 of the laws of 2019, are amended to read as follows:

22 (v) meets standards specified and determined by the Marketplace,  
23 provided that the standards do not conflict with or prevent the applica-  
24 tion of federal requirements; [and]

25 (vi) contracts with any national cancer institute-designated cancer  
26 center licensed by the department within the health plan's service area  
27 that is willing to agree to provide cancer-related inpatient, outpatient  
28 and medical services to enrollees in all health plans offering coverage

1 through the Marketplace in such cancer center's service area under the  
2 prevailing terms and conditions that the plan requires of other similar  
3 providers to be included in the plan's provider network, provided that  
4 such terms shall include reimbursement of such center at no less than  
5 the fee-for-service medicaid payment rate and methodology applicable to  
6 the center's inpatient and outpatient services; and

7 (vii) complies with the insurance law and this chapter requirements  
8 applicable to health insurance issued in this state and any regulations  
9 promulgated pursuant thereto that do not conflict with or prevent the  
10 application of federal requirements; and

11 § 8. Subdivision 4 of section 364-j of the social services law is  
12 amended by adding a new paragraph (w) to read as follows:

13 (w) A managed care provider shall provide or arrange, directly or  
14 indirectly, including by referral, for access to and coverage of  
15 services provided by any national cancer institute-designated cancer  
16 center licensed by the department of health within the managed care  
17 provider's service area that is willing to agree to provide cancer-re-  
18 lated inpatient, outpatient and medical services to participants in all  
19 managed care providers offering coverage to medical assistance recipi-  
20 ents in such cancer center's service area under the prevailing terms and  
21 conditions that the managed care provider requires of other similar  
22 providers to be included in the managed care provider's network,  
23 provided that such terms shall include reimbursement of such center at  
24 no less than the fee-for-service medicaid payment rate and methodology  
25 applicable to the center's inpatient and outpatient services.

26 § 9. Paragraph (c) of subdivision 1 of section 369-gg of the social  
27 services law, as amended by section 2 of part H of chapter 57 of the  
28 laws of 2021, is amended to read as follows:



1 (c) "Health care services" means (i) the services and supplies as  
2 defined by the commissioner in consultation with the superintendent of  
3 financial services, and shall be consistent with and subject to the  
4 essential health benefits as defined by the commissioner in accordance  
5 with the provisions of the patient protection and affordable care act  
6 (P.L. 111-148) and consistent with the benefits provided by the refer-  
7 ence plan selected by the commissioner for the purposes of defining such  
8 benefits, and shall include coverage of and access to the services of  
9 any national cancer institute-designated cancer center licensed by the  
10 department of health within the service area of the approved organiza-  
11 tion that is willing to agree to provide cancer-related inpatient,  
12 outpatient and medical services to all enrollees in approved organiza-  
13 tions' plans in such cancer center's service area under the prevailing  
14 terms and conditions that the approved organization requires of other  
15 similar providers to be included in the approved organization's network,  
16 provided that such terms shall include reimbursement of such center at  
17 no less than the fee-for-service medicaid payment rate and methodology  
18 applicable to basic health program plan payments for inpatient and  
19 outpatient services; and (ii) dental and vision services as defined by  
20 the commissioner;

21 § 10. Severability. If any clause, sentence, paragraph, section or  
22 part of this act shall be adjudged by any court of competent jurisdic-  
23 tion to be invalid and after exhaustion of all further judicial review,  
24 the judgment shall not affect, impair or invalidate the remainder there-  
25 of, but shall be confined in its operation to the clause, sentence,  
26 paragraph, section or part of this act directly involved in the contro-  
27 versy in which the judgment shall have been rendered.

1 § 11. Sections one, two, three, four, five, six and ten of this act  
2 shall take effect immediately; sections seven, eight and nine shall take  
3 effect on the first of January next succeeding the date on which it  
4 shall have become a law and shall apply to all coverage or policies  
5 issued or renewed on or after such effective date and shall expire and  
6 be deemed repealed five years after such date; provided, however, that  
7 the amendments to section 364-j of the social services law made by  
8 sections one, two and eight of this act, the amendments to section  
9 4403-f of the public health law made by sections four, five and six of  
10 this act and the amendments to paragraph (c) of subdivision 1 of section  
11 369-gg of the social services law made by section nine of this act shall  
12 not affect the repeal of such sections or such paragraph and shall be  
13 deemed repealed therewith; provided, further, that this act shall not be  
14 construed to prohibit managed care providers participating in the  
15 managed care program and managed long term care plans approved to  
16 provide health and long term care services to enrollees who are eligible  
17 under title XIX of the federal social security act, that were so author-  
18 ized as of the date this act becomes effective, from continuing oper-  
19 ations as authorized until such time as awards are made in accordance  
20 with this act and such additional time subject to direction from the  
21 commissioner of health to ensure the safe and orderly transfer of  
22 participants.

23

## PART Q

24 Section 1. Section 268-c of the public health law is amended by adding  
25 a new subdivision 25 to read as follows:

1     25. The commissioner is authorized to submit the appropriate waiver  
2 applications to the United States secretary of health and human services  
3 and/or the department of the treasury to waive any applicable provisions  
4 of the Patient Protection and Affordable Care Act, Pub. L. 111-148 as  
5 amended, or successor provisions, as provided for by 42 U.S.C. 18052,  
6 and any other waivers necessary to achieve the purposes of high quality,  
7 affordable coverage through NY State of Health, the official health plan  
8 marketplace. The commissioner shall implement the state plans of any  
9 such waiver in a manner consistent with applicable state and federal  
10 laws, as authorized by the secretary of health and human services and/or  
11 the secretary of the treasury pursuant to 42 U.S.C. 18052. Copies of  
12 such original waiver applications and amendments thereto shall be  
13 provided to the chair of the senate finance committee, the chair of the  
14 assembly ways and means committee and the chairs of the senate and  
15 assembly health committees simultaneously with their submission to the  
16 federal government.

17     § 2. Paragraph (d) of subdivision 3 of section 369-gg of the social  
18 services law, as amended by section 2 of part H of chapter 57 of the  
19 laws of 2021, is amended to read as follows:

20     (d) (i) except as provided by subparagraph (ii) of this paragraph, has  
21 household income at or below two hundred percent of the federal poverty  
22 line defined and annually revised by the United States department of  
23 health and human services for a household of the same size; and [(ii)]  
24 has household income that exceeds one hundred thirty-three percent of  
25 the federal poverty line defined and annually revised by the United  
26 States department of health and human services for a household of the  
27 same size; however, MAGI eligible aliens lawfully present in the United  
28 States with household incomes at or below one hundred thirty-three

1 percent of the federal poverty line shall be eligible to receive cover-  
2 age for health care services pursuant to the provisions of this title if  
3 such alien would be ineligible for medical assistance under title eleven  
4 of this article due to [his or her] their immigration status[.];

5 (ii) subject to federal approval and the use of state funds, unless  
6 the commissioner may use funds under subdivision seven of this section,  
7 has household income at or below two hundred fifty percent of the feder-  
8 al poverty line defined and annually revised by the United States  
9 department of health and human services for a household of the same  
10 size; and has household income that exceeds one hundred thirty-three  
11 percent of the federal poverty line defined and annually revised by the  
12 United States department of health and human services for a household of  
13 the same size; however, MAGI eligible aliens lawfully present in the  
14 United States with household incomes at or below one hundred thirty-  
15 three percent of the federal poverty line shall be eligible to receive  
16 coverage for health care services pursuant to the provisions of this  
17 title if such alien would be ineligible for medical assistance under  
18 title eleven of this article due to their immigration status;

19 (iii) subject to federal approval if required and the use of state  
20 funds, unless the commissioner may use funds under subdivision seven of  
21 this section, a pregnant individual who is eligible to receive coverage  
22 for health care services pursuant to subparagraph (i) or (ii) of this  
23 paragraph is eligible to receive and/or to continue to receive health  
24 care services pursuant to this title during the pregnancy and for a  
25 period of one year following the end of the pregnancy without regard to  
26 any change in the income of the household that includes the pregnant  
27 individual, even if such change would render the pregnant individual  
28 ineligible to receive health care services pursuant to this title; or

1 (iv) subject to federal approval, a child born to an individual eligi-  
2 ble for and receiving coverage for health care services pursuant to this  
3 title shall be deemed to have applied for medical assistance and to have  
4 been found eligible for such assistance on the date of such birth and to  
5 remain eligible for such assistance for a period of one year.

6 An applicant who fails to make an applicable premium payment, if any,  
7 shall lose eligibility to receive coverage for health care services in  
8 accordance with time frames and procedures determined by the commission-  
9 er.

10 § 3. Paragraph (d) of subdivision 3 of section 369-gg of the social  
11 services law, as added by section 51 of part C of chapter 60 of the laws  
12 of 2014, is amended to read as follows:

13 (d) (i) except as provided by subparagraph (ii) of this paragraph, has  
14 household income at or below two hundred percent of the federal poverty  
15 line defined and annually revised by the United States department of  
16 health and human services for a household of the same size; and [(ii)]  
17 has household income that exceeds one hundred thirty-three percent of  
18 the federal poverty line defined and annually revised by the United  
19 States department of health and human services for a household of the  
20 same size; however, MAGI eligible aliens lawfully present in the United  
21 States with household incomes at or below one hundred thirty-three  
22 percent of the federal poverty line shall be eligible to receive cover-  
23 age for health care services pursuant to the provisions of this title if  
24 such alien would be ineligible for medical assistance under title eleven  
25 of this article due to [his or her] their immigration status[.];

26 (ii) subject to federal approval and the use of state funds, unless  
27 the commissioner may use funds under subdivision seven of this section,  
28 has household income at or below two hundred fifty percent of the feder-

1 al poverty line defined and annually revised by the United States  
2 department of health and human services for a household of the same  
3 size; and has household income that exceeds one hundred thirty-three  
4 percent of the federal poverty line defined and annually revised by the  
5 United States department of health and human services for a household of  
6 the same size; however, MAGI eligible aliens lawfully present in the  
7 United States with household incomes at or below one hundred thirty-  
8 three percent of the federal poverty line shall be eligible to receive  
9 coverage for health care services pursuant to the provisions of this  
10 title if such alien would be ineligible for medical assistance under  
11 title eleven of this article due to their immigration status;

12 (iii) subject to federal approval if required and the use of state  
13 funds, unless the commissioner may use funds under subdivision seven of  
14 this section, a pregnant individual who is eligible to receive coverage  
15 for health care services pursuant to subparagraph (i) or (ii) of this  
16 paragraph is eligible to receive and/or to continue to receive health  
17 care services pursuant to this title during the pregnancy and for a  
18 period of one year following the end of the pregnancy without regard to  
19 any change in the income of the household that includes the pregnant  
20 individual, even if such change would render the pregnant individual  
21 ineligible to receive health care services pursuant to this title; or

22 (iv) subject to federal approval, a child born to an individual eligi-  
23 ble for and receiving coverage for health care services pursuant to this  
24 title shall be deemed to have applied for medical assistance and to have  
25 been found eligible for such assistance on the date of such birth and to  
26 remain eligible for such assistance for a period of one year.

1 An applicant who fails to make an applicable premium payment shall  
2 lose eligibility to receive coverage for health care services in accord-  
3 ance with time frames and procedures determined by the commissioner.

4 § 4. Paragraph (c) of subdivision 1 of section 369-gg of the social  
5 services law, as amended by section 2 of part H of chapter 57 of the  
6 laws of 2021, is amended to read as follows:

7 (c) "Health care services" means (i) the services and supplies as  
8 defined by the commissioner in consultation with the superintendent of  
9 financial services, and shall be consistent with and subject to the  
10 essential health benefits as defined by the commissioner in accordance  
11 with the provisions of the patient protection and affordable care act  
12 (P.L. 111-148) and consistent with the benefits provided by the refer-  
13 ence plan selected by the commissioner for the purposes of defining such  
14 benefits, [and] (ii) dental and vision services as defined by the  
15 commissioner, and (iii) as defined by the commissioner and subject to  
16 federal approval, certain services and supports provided to enrollees  
17 eligible pursuant to subparagraph one of paragraph (g) of subdivision  
18 one of section three hundred sixty-six of this article who have func-  
19 tional limitations and/or chronic illnesses that have the primary  
20 purpose of supporting the ability of the enrollee to live or work in the  
21 setting of their choice, which may include the individual's home, a  
22 worksite, or a provider-owned or controlled residential setting;

23 § 5. Paragraph (c) of subdivision 1 of section 369-gg of the social  
24 services law, as added by section 51 of part C of chapter 60 of the laws  
25 of 2014, is amended to read as follows:

26 (c) "Health care services" means (i) the services and supplies as  
27 defined by the commissioner in consultation with the superintendent of  
28 financial services, and shall be consistent with and subject to the

1 essential health benefits as defined by the commissioner in accordance  
2 with the provisions of the patient protection and affordable care act  
3 (P.L. 111-148) and consistent with the benefits provided by the refer-  
4 ence plan selected by the commissioner for the purposes of defining such  
5 benefits, and (ii) as defined by the commissioner and subject to federal  
6 approval, certain services and supports provided to enrollees eligible  
7 pursuant to subparagraph one of paragraph (g) of subdivision one of  
8 section three hundred sixty-six of this article who have functional  
9 limitations and/or chronic illnesses that have the primary purpose of  
10 supporting the ability of the enrollee to live or work in the setting of  
11 their choice, which may include the individual's home, a worksite, or a  
12 provider-owned or controlled residential setting;

13 § 6. Paragraph (c) of subdivision 1 of section 369-gg of the social  
14 services law, as amended by section 2 of part H of chapter 57 of the  
15 laws of 2021, is amended to read as follows:

16 (c) "Health care services" means (i) the services and supplies as  
17 defined by the commissioner in consultation with the superintendent of  
18 financial services, and shall be consistent with and subject to the  
19 essential health benefits as defined by the commissioner in accordance  
20 with the provisions of the patient protection and affordable care act  
21 (P.L. 111-148) and consistent with the benefits provided by the refer-  
22 ence plan selected by the commissioner for the purposes of defining such  
23 benefits, [and] (ii) dental and vision services as defined by the  
24 commissioner, and (iii) as defined by the commissioner and subject to  
25 federal approval, certain services and supports provided to enrollees  
26 who have functional limitations and/or chronic illnesses that have the  
27 primary purpose of supporting the ability of the enrollee to live or



1 work in the setting of their choice, which may include the individual's  
2 home, a worksite, or a provider-owned or controlled residential setting;

3 § 7. Paragraph (c) of subdivision 1 of section 369-gg of the social  
4 services law, as added by section 51 of part C of chapter 60 of the laws  
5 of 2014, is amended to read as follows:

6 (c) "Health care services" means (i) the services and supplies as  
7 defined by the commissioner in consultation with the superintendent of  
8 financial services, and shall be consistent with and subject to the  
9 essential health benefits as defined by the commissioner in accordance  
10 with the provisions of the patient protection and affordable care act  
11 (P.L. 111-148) and consistent with the benefits provided by the refer-  
12 ence plan selected by the commissioner for the purposes of defining such  
13 benefits, and (ii) as defined by the commissioner and subject to federal  
14 approval, certain services and supports provided to enrollees who have  
15 functional limitations and/or chronic illnesses that have the primary  
16 purpose of supporting the ability of the enrollee to live or work in the  
17 setting of their choice, which may include the individual's home, a  
18 worksite, or a provider-owned or controlled residential setting;

19 § 8. This act shall take effect immediately and shall be deemed to  
20 have been in full force and effect on and after April 1, 2022, provided  
21 however:

22 (a) the amendments to paragraph (d) of subdivision 3 of section 369-gg  
23 of the social services law made by section two of this act shall be  
24 subject to the expiration and reversion of such paragraph pursuant to  
25 section 3 of part H of chapter 57 of the laws of 2021 as amended, when  
26 upon such date the provisions of section three of this act shall take  
27 effect;

1 (b) section four of this act shall take effect January 1, 2023 and  
2 shall expire and be deemed repealed December 31, 2024; provided, howev-  
3 er, the amendments to paragraph (c) of subdivision 1 of section 369-gg  
4 of the social services law made by such section of this act shall be  
5 subject to the expiration and reversion of such paragraph pursuant to  
6 section 2 of part H of chapter 57 of the laws of 2021 when upon such  
7 date, the provisions of section five of this act shall take effect;  
8 provided, however, the amendments to such paragraph made by section five  
9 of this act shall expire and be deemed repealed December 31, 2024; and  
10 (c) section six of this act shall take effect January 1, 2025;  
11 provided, however, the amendments to paragraph (c) of subdivision 1 of  
12 section 369-gg of the social services law made by such section of this  
13 act shall be subject to the expiration and reversion of such paragraph  
14 pursuant to section 2 of part H of chapter 57 of the laws of 2021 when  
15 upon such date, the provisions of section seven of this act shall take  
16 effect.

17 PART R

18 Section 1. Subsection (i) of section 3216 of the insurance law is  
19 amended by adding a new paragraph 36 to read as follows:

20 (36) Every policy that provides medical, major medical or similar  
21 comprehensive type coverage delivered or issued for delivery in this  
22 state shall provide coverage for abortions. Coverage for abortions shall  
23 not be subject to copayments, or coinsurance, or annual deductibles,  
24 unless the policy is a high deductible health plan, as defined in 26  
25 U.S.C. § 223(c)(2), in which case coverage for abortions may be subject  
26 to the plan's annual deductible.

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

3 (22) (A) Except as provided in subparagraph (B) of this paragraph,  
4 every group or blanket policy that provides medical, major medical, or  
5 similar comprehensive type coverage delivered or issued for delivery in  
6 this state shall provide coverage for abortions. Coverage for abortions  
7 shall not be subject to copayments, or coinsurance, or annual deduct-  
8 ibles, unless the policy is a high deductible health plan, as defined in  
9 26 U.S.C. § 223(c)(2), in which case coverage for abortions may be  
10 subject to the plan's annual deductible.

11 (B) A group or blanket policy that provides medical, major medical, or  
12 similar comprehensive type coverage to a religious employer may exclude  
13 coverage for abortions only if the insurer:

14 (i) obtains an annual certification from the group or blanket policy-  
15 holder that the policyholder is a religious employer and that the reli-  
16 gious employer requests a policy without coverage for abortions;

17 (ii) issues a rider to each certificate holder at no premium to be  
18 charged to the certificate holder or religious employer for the rider,  
19 that provides coverage for abortions subject to the same rules as would  
20 have been applied to the same category of treatment in the policy issued  
21 to the religious employer. The rider shall clearly and conspicuously  
22 specify that the religious employer does not administer abortion bene-  
23 fits, but that the insurer is issuing a rider for coverage of abortions,  
24 and shall provide the insurer's contact information for questions; and

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

27 (C) For the purpose of this paragraph, "religious employer" means an  
28 entity:

1 (i) for which the inculcation of religious values is the purpose of  
2 the entity;

3 (ii) that primarily employs persons who share the religious tenets of  
4 the entity;

5 (iii) that serves primarily persons who share the religious tenets of  
6 the entity; and

7 (iv) that is a nonprofit organization as described in 26 U.S.C. §  
8 6033(a)(3)(A)(i) or (iii).

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

11 (ss)(1) Except as provided in paragraph two of this subsection, every  
12 individual and group contract that provides medical, major medical or  
13 similar comprehensive type coverage delivered or issued for delivery in  
14 this state shall provide coverage for abortions. Coverage for abortions  
15 shall not be subject to copayments, or coinsurance, or annual deduct-  
16 ibles, unless the contract is a high deductible health plan, as defined  
17 in 26 U.S.C. § 223(c)(2), in which case coverage for abortions may be  
18 subject to the plan's annual deductible.

19 (2) A group contract that provides medical, major medical, or similar  
20 comprehensive type coverage to a religious employer may exclude coverage  
21 for abortions only if the corporation:

22 (A) obtains an annual certification from the group contract holder  
23 that the contract holder is a religious employer and that the religious  
24 employer requests a contract without coverage for abortions;

25 (B) issues a rider to each certificate holder at no premium to be  
26 charged to the certificate holder or religious employer for the rider,  
27 that provides coverage for abortions subject to the same rules as would  
28 have been applied to the same category of treatment in the contract

1 issued to the religious employer. The rider shall clearly and conspicu-  
2 ously specify that the religious employer does not administer abortion  
3 benefits, but that the corporation is issuing a rider for coverage of  
4 abortions, and shall provide the corporation's contact information for  
5 questions; and

6 (iii) provides notice of the issuance of the contract and rider to the  
7 superintendent in a form and manner acceptable to the superintendent.

8 (3) For the purpose of this subsection, "religious employer" means an  
9 entity:

10 (A) for which the inculcation of religious values is the purpose of  
11 the entity;

12 (B) that primarily employs persons who share the religious tenets of  
13 the entity;

14 (C) that serves primarily persons who share the religious tenets of  
15 the entity; and

16 (D) that is a nonprofit organization as described in 26 U.S.C. §  
17 6033(a)(3)(A)(i) or (iii).

18 § 4. This act shall take effect on the first of January next succeed-  
19 ing the date on which it shall have become a law and shall apply to all  
20 policies and contracts issued, renewed, modified, altered, or amended on  
21 or after such date. Effective immediately, the addition, amendment, or  
22 repeal of any rule or regulation necessary for the implementation of  
23 this act on its effective date are authorized to be made and completed  
24 on or before such effective date.

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

3 (jj) pre-natal and post-partum care and services for the purpose of  
4 improving maternal health outcomes and reduction of maternal mortality,  
5 as determined by the commissioner of health, when such services are  
6 recommended by a physician or other licensed practitioner of the healing  
7 arts, and provided by qualified practitioners, as determined by the  
8 commissioner of health; provided, however, that the provisions of this  
9 paragraph shall not take effect unless all necessary approvals under  
10 federal law and regulation have been obtained to receive federal finan-  
11 cial participation in the costs of services provided pursuant to this  
12 paragraph. Nothing in this paragraph shall be construed to modify any  
13 licensure, certification or scope of practice provision under title  
14 eight of the education law.

15 § 2. Subparagraph 3 of paragraph (d) of subdivision 1 of section 366  
16 of the social services law, as added by section 1 of part D of chapter  
17 56 of the laws of 2013, is amended to read as follows:

18 (3) cooperates with the appropriate social services official or the  
19 department in establishing paternity or in establishing, modifying, or  
20 enforcing a support order with respect to his or her child; provided,  
21 however, that nothing herein contained shall be construed to require a  
22 payment under this title for care or services, the cost of which may be  
23 met in whole or in part by a third party; notwithstanding the foregoing,  
24 a social services official shall not require such cooperation if the  
25 social services official or the department determines that such actions  
26 would be detrimental to the best interest of the child, applicant, or  
27 recipient, or with respect to pregnant women during pregnancy and during  
28 the [sixty-day] one year period beginning on the last day of pregnancy,

1 in accordance with procedures and criteria established by regulations of  
2 the department consistent with federal law; and

3 § 3. Subparagraph 1 of paragraph (b) of subdivision 4 of section 366  
4 of the social services law, as added by section 2 of part D of chapter  
5 56 of the laws of 2013, is amended to read as follows:

6 (1) A pregnant woman eligible for medical assistance under subpara-  
7 graph two or four of paragraph (b) of subdivision one of this section on  
8 any day of her pregnancy will continue to be eligible for such care and  
9 services [through the end of the month in which the sixtieth day follow-  
10 ing the end of the pregnancy occurs,] for a period of one year beginning  
11 on the last day of pregnancy, without regard to any change in the income  
12 of the family that includes the pregnant woman, even if such change  
13 otherwise would have rendered her ineligible for medical assistance.  
14 Notwithstanding the provisions of this subparagraph, individuals who  
15 meet the eligibility requirements for medical assistance under subpara-  
16 graph eight of paragraph (b) of subdivision one of this section, shall  
17 continue to be eligible for medical assistance under this subparagraph  
18 through the end of the month in which the sixtieth day following the  
19 last day of the pregnancy occurs.

20 § 4. Paragraph (b) of subdivision 1 of section 366 of the social  
21 services law is amended by adding a new subparagraph 8 to read as  
22 follows:

23 (8) Notwithstanding the provisions of subparagraph two of this para-  
24 graph, a pregnant individual that is ineligible for federally funded  
25 medical assistance solely due to their immigration status is eligible  
26 for standard coverage if their MAGI household income does not exceed the  
27 MAGI-equivalent of two hundred percent of the federal poverty line for  
28 the applicable family size, which shall be calculated in accordance with

1 guidance issued by the secretary of the United States department of  
2 health and human services.

3 § 5. Section 369-hh of the social services law is REPEALED.

4 § 6. This act shall take effect immediately and shall be deemed to  
5 have been in full force and effect on and after April 1, 2022; provided,  
6 however, that sections two, three, four and five of this act shall take  
7 effect January 1, 2023.

8 PART T

9 Section 1. Subdivision 1 of section 2308 of the public health law is  
10 amended to read as follows:

11 1. Every physician or other authorized practitioner attending pregnant  
12 [women] patients in the state shall in the case of every [woman] patient  
13 so attended take or cause to be taken a sample of blood of such [woman]  
14 patient at the time of first examination, and submit such sample to an  
15 approved laboratory for a standard serological test for syphilis. In  
16 addition to testing at the time of first examination, every such physi-  
17 cian or other authorized practitioner shall order a syphilis test during  
18 the third trimester of pregnancy consistent with any guidance and regu-  
19 lations issued by the commissioner.

20 § 2. This act shall take effect one year after it shall have become a  
21 law. Effective immediately, any rules and regulations or guidance neces-  
22 sary to implement the provisions of this act on its effective date are  
23 authorized to be amended, repealed and/or promulgated on or before such  
24 date.

25 PART U



1 Section 1. Subdivision 7 of section 2510 of the public health law, as  
2 amended by chapter 436 of the laws of 2021, is amended to read as  
3 follows:

4 7. "Covered health care services" means: the services of physicians,  
5 optometrists, nurses, nurse practitioners, midwives and other related  
6 professional personnel which are provided on an outpatient basis,  
7 including routine well-child visits; diagnosis and treatment of illness  
8 and injury; inpatient health care services; laboratory tests; diagnostic  
9 x-rays; prescription and non-prescription drugs, ostomy and other  
10 medical supplies and durable medical equipment; radiation therapy;  
11 chemotherapy; hemodialysis; outpatient blood clotting factor products  
12 and other treatments and services furnished in connection with the care  
13 of hemophilia and other blood clotting protein deficiencies; emergency  
14 room services; ambulance services; hospice services; emergency, preven-  
15 tive and routine dental care, including [medically necessary] orthodon-  
16 tia but excluding cosmetic surgery; emergency, preventive and routine  
17 vision care, including eyeglasses; speech and hearing services; [and,]  
18 inpatient and outpatient mental health, alcohol and substance abuse  
19 services, including children and family treatment and support services,  
20 children's home and community based services, assertive community treat-  
21 ment services and residential rehabilitation for youth services; and  
22 health-related services provided by voluntary foster care agency health  
23 facilities licensed pursuant to article twenty-nine-I of this chapter;  
24 as defined by the commissioner [in consultation with the superinten-  
25 dent]. "Covered health care services" shall not include drugs, proce-  
26 dures and supplies for the treatment of erectile dysfunction when  
27 provided to, or prescribed for use by, a person who is required to  
28 register as a sex offender pursuant to article six-C of the correction

1 law, provided that any denial of coverage of such drugs, procedures or  
2 supplies shall provide the patient with the means of obtaining addi-  
3 tional information concerning both the denial and the means of challeng-  
4 ing such denial.

5 § 2. Subdivision 9 of section 2510 of the public health law is amended  
6 by adding a new paragraph (e) to read as follows:

7 (e) for periods on or after October first, two thousand twenty-two,  
8 amounts as follows:

9 (i) no payments are required for eligible children whose family house-  
10 hold income is less than two hundred twenty-three percent of the non-  
11 farm federal poverty level and for eligible children who are American  
12 Indians or Alaskan Natives, as defined by the United States department  
13 of health and human services, whose family household income is less than  
14 two hundred fifty-one percent of the non-farm federal poverty level; and

15 (ii) fifteen dollars per month for each eligible child whose family  
16 household income is between two hundred twenty-three percent and two  
17 hundred fifty percent of the non-farm federal poverty level, but no more  
18 than forty-five dollars per month per family; and

19 (iii) thirty dollars per month for each eligible child whose family  
20 household income is between two hundred fifty-one percent and three  
21 hundred percent of the non-farm federal poverty level, but no more than  
22 ninety dollars per month per family; and

23 (iv) forty-five dollars per month for each eligible child whose family  
24 household income is between three hundred one percent and three hundred  
25 fifty percent of the non-farm federal poverty level, but no more than  
26 one hundred thirty-five dollars per month per family; and

27 (v) sixty dollars per month for each eligible child whose family  
28 household income is between three hundred fifty-one percent and four

1 hundred percent of the non-farm federal poverty level, but no more than  
2 one hundred eighty dollars per month per family.

3 § 3. Subdivision 8 of section 2511 of the public health law is amended  
4 by adding a new paragraph (i) to read as follows:

5 (i) Notwithstanding any inconsistent provision of this title, arti-  
6 cles thirty-two and forty-three of the insurance law and subsection (e)  
7 of section eleven hundred twenty of the insurance law:

8 (i) The commissioner shall, subject to approval of the director of the  
9 division of the budget, develop reimbursement methodologies for deter-  
10 mining the amount of subsidy payments made to approved organizations for  
11 the cost of covered health care services coverage provided pursuant to  
12 this title for payments made on and after January first, two thousand  
13 twenty-four.

14 (ii) Effective January first, two thousand twenty-three, the commis-  
15 sioner shall coordinate with the superintendent of financial services  
16 for the transition of the subsidy payment rate setting function to the  
17 department and, in conjunction with its independent actuary, review  
18 reimbursement methodologies developed in accordance with subparagraph  
19 (i) of this paragraph. Notwithstanding section one hundred sixty-three  
20 of the state finance law, the commissioner may select and contract with  
21 the independent actuary selected pursuant to subdivision eighteen of  
22 section three hundred sixty-four-j of the social services law, without a  
23 competitive bid or request for proposal process. Such independent actu-  
24 ary shall review and make recommendations concerning appropriate actuar-  
25 ial assumptions relevant to the establishment of reimbursement methodol-  
26 ogies, including but not limited to the adequacy of subsidy payment  
27 amounts in relation to the population to be served adjusted for case  
28 mix, the scope of services approved organizations must provide, the

1 utilization of such services and the network of providers required to  
2 meet state standards.

3 § 4. Paragraph b of subdivision 7 of section 2511 of the public health  
4 law, as amended by chapter 923 of the laws of 1990, is amended to read  
5 as follows:

6 (b) The commissioner, in consultation with the superintendent, shall  
7 make a determination whether to approve, disapprove or recommend modifi-  
8 cation of the proposal. In order for a proposal to be approved by the  
9 commissioner, the proposal must also be approved by the superintendent  
10 with respect to the provisions of subparagraphs [(viii) through] (ix)  
11 and (xii) of paragraph (a) of this subdivision.

12 § 5. This act shall take effect immediately; provided, however, that  
13 sections one, three and four of this act shall take effect January 1,  
14 2023 and section two of this act shall take effect April 1, 2022.

15 PART V

16 Section 1. Subdivision 1 of section 2999-dd of the public health law,  
17 as amended by chapter 124 of the laws of 2020, is amended to read as  
18 follows:

19 1. Health care services delivered by means of telehealth shall be  
20 entitled to reimbursement under section three hundred sixty-seven-u of  
21 the social services law on the same basis, at the same rate, and to the  
22 same extent the equivalent services, as may be defined in regulations  
23 promulgated by the commissioner, are reimbursed when delivered in  
24 person; provided, however, that health care services delivered by means  
25 of telehealth shall not require reimbursement to a telehealth provider  
26 for certain costs, including but not limited to facility fees or costs

1 reimbursed through ambulatory patient groups or other clinic reimburse-  
2 ment methodologies set forth in section twenty-eight hundred seven of  
3 this chapter, if such costs were not incurred in the provision of tele-  
4 health services due to neither the originating site nor the distant site  
5 occurring within a facility or other clinic setting; and further  
6 provided, however, reimbursement for additional modalities, provider  
7 categories and originating sites specified in accordance with section  
8 twenty-nine hundred ninety-nine-ee of this article, and audio-only tele-  
9 phone communication defined in regulations promulgated pursuant to  
10 subdivision four of section twenty-nine hundred ninety-nine-cc of this  
11 article, shall be contingent upon federal financial participation.  
12 Notwithstanding the provisions of this subdivision, for services  
13 licensed, certified or otherwise authorized pursuant to article sixteen,  
14 article thirty-one or article thirty-two of the mental hygiene law, such  
15 services provided by telehealth, as deemed appropriate by the relevant  
16 commissioner, shall be reimbursed at the applicable in person rates or  
17 fees established by law, or otherwise established or certified by the  
18 office for people with developmental disabilities, office of mental  
19 health, or the office of addiction services and supports pursuant to  
20 article forty-three of the mental hygiene law.

21 § 2. Subsection (a) of section 3217-h of the insurance law, as added  
22 by chapter 6 of the laws of 2015, is amended to read as follows:

23 (a) (1) An insurer shall not exclude from coverage a service that is  
24 otherwise covered under a policy that provides comprehensive coverage  
25 for hospital, medical or surgical care because the service is delivered  
26 via telehealth, as that term is defined in subsection (b) of this  
27 section; provided, however, that an insurer may exclude from coverage a  
28 service by a health care provider where the provider is not otherwise

1 covered under the policy. An insurer may subject the coverage of a  
2 service delivered via telehealth to co-payments, coinsurance or deduct-  
3 ibles provided that they are at least as favorable to the insured as  
4 those established for the same service when not delivered via tele-  
5 health. An insurer may subject the coverage of a service delivered via  
6 telehealth to reasonable utilization management and quality assurance  
7 requirements that are consistent with those established for the same  
8 service when not delivered via telehealth.

9 (2) An insurer that provides comprehensive coverage for hospital,  
10 medical or surgical care shall reimburse covered services delivered by  
11 means of telehealth on the same basis, at the same rate, and to the same  
12 extent that such services are reimbursed when delivered in person;  
13 provided that reimbursement of covered services delivered via telehealth  
14 shall not require reimbursement of costs not actually incurred in the  
15 provision of the telehealth services, including charges related to the  
16 use of a clinic or other facility when neither the originating site nor  
17 distant site occur within the clinic or other facility.

18 (3) An insurer that provides comprehensive coverage for hospital,  
19 medical, or surgical care with a network of health care providers shall  
20 ensure that such network is adequate to meet the telehealth needs of  
21 insured individuals for services covered under the policy when medically  
22 appropriate.

23 § 3. Subsection (a) of section 4306-g of the insurance law, as added  
24 by chapter 6 of the laws of 2015, is amended to read as follows:

25 (a) (1) A corporation shall not exclude from coverage a service that  
26 is otherwise covered under a contract that provides comprehensive cover-  
27 age for hospital, medical or surgical care because the service is deliv-  
28 ered via telehealth, as that term is defined in subsection (b) of this

1 section; provided, however, that a corporation may exclude from coverage  
2 a service by a health care provider where the provider is not otherwise  
3 covered under the contract. A corporation may subject the coverage of a  
4 service delivered via telehealth to co-payments, coinsurance or deduct-  
5 ibles provided that they are at least as favorable to the insured as  
6 those established for the same service when not delivered via tele-  
7 health. A corporation may subject the coverage of a service delivered  
8 via telehealth to reasonable utilization management and quality assur-  
9 ance requirements that are consistent with those established for the  
10 same service when not delivered via telehealth.

11 (2) A corporation that provides comprehensive coverage for hospital,  
12 medical or surgical care shall reimburse covered services delivered by  
13 means of telehealth on the same basis, at the same rate, and to the same  
14 extent that such services are reimbursed when delivered in person;  
15 provided that reimbursement of covered services delivered via tele-  
16 health shall not require reimbursement of costs not actually incurred  
17 in the provision of the telehealth services, including charges related  
18 to the use of a clinic or other facility when neither the originating  
19 site nor the distant site occur within the clinic or other facility. The  
20 superintendent may promulgate regulations to implement the provisions  
21 of this section.

22 (3) A corporation that provides comprehensive coverage for hospital,  
23 medical, or surgical care with a network of health care providers shall  
24 ensure that such network is adequate to meet the telehealth needs of  
25 insured individuals for services covered under the policy when medically  
26 appropriate.

27 § 4. Section 4406-g of the public health law is amended by adding two  
28 new subdivisions 3 and 4 to read as follows:

1 3. A health maintenance organization that provides comprehensive  
2 coverage for hospital, medical or surgical care shall reimburse covered  
3 services delivered via telehealth on the same basis, at the same rate,  
4 and to the extent that such services are reimbursed when delivered in  
5 person; provided that reimbursement of covered services delivered by  
6 means of telehealth shall not require reimbursement of costs not actu-  
7 ally incurred in the provision of the telehealth services, including  
8 charges related to the use of a clinic or other facility when neither  
9 the originating site nor the distant site occur within the clinic or  
10 other facility. The commissioner, in consultation with the superinten-  
11 dent, may promulgate regulations to implement the provisions of this  
12 section.

13 4. A health maintenance organization that provides comprehensive  
14 coverage for hospital, medical, or surgical care with a network of  
15 health care providers shall ensure that such network is adequate to meet  
16 the telehealth needs of insured individuals for services covered under  
17 the policy when medically appropriate.

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

20 PART W

21 Section 1. Section 365-g of the social services law, as added by chap-  
22 ter 938 of the laws of 1990, subdivisions 1 and 3 as amended by chapter  
23 165 of the laws of 1991, subdivisions 2 and 4 as amended by section 31  
24 of part C of chapter 58 of the laws of 2008, clause (B) of subparagraph  
25 (iii) of paragraph (b) of subdivision 3 as amended by chapter 59 of the  
26 laws of 1993, subparagraphs (vi) and (vii) of paragraph (b) of subdivi-



1 sion 3 as amended and subparagraph (viii) as added by section 31-b of  
2 part C of chapter 58 of the laws of 2008, subdivision 5 as amended by  
3 chapter 41 of the laws of 1992, paragraphs (f) and (g) of subdivision 5  
4 as amended by and paragraphs (h) and (i) as added by section 31-a of  
5 part C of chapter 58 of the laws of 2008, is amended to read as follows:

6 § 365-g. Utilization [thresholds] review for certain care, services  
7 and supplies. 1. The department may implement a system for utilization  
8 [controls] review, pursuant to this section, for persons eligible for  
9 benefits under this title, [including annual service limitations or  
10 utilization thresholds above which the department may not pay for addi-  
11 tional care, services or supplies, unless such care, services or  
12 supplies have been previously approved by the department or unless such  
13 care, services or supplies were provided pursuant to subdivision three,  
14 four or five of this section] to evaluate the appropriateness and quali-  
15 ty of medical assistance, and safeguard against unnecessary utilization  
16 of care and services, which shall include a post-payment review process  
17 to develop and review beneficiary utilization profiles, provider service  
18 profiles, and exceptions criteria to correct misutilization practices of  
19 beneficiaries and providers; and for referral to the office of Medicaid  
20 inspector general where suspected fraud, waste or abuse are identified  
21 in the unnecessary or inappropriate use of care, services or supplies  
22 furnished under this title.

23 2. The department may [implement] review utilization [thresholds] by  
24 provider service type, medical procedure and patient, in consultation  
25 with the state department of mental hygiene, other appropriate state  
26 agencies, and other stakeholders including provider and consumer repre-  
27 sentatives. In [developing] reviewing utilization [thresholds], the  
28 department shall consider historical recipient utilization patterns,

1 patient-specific diagnoses and burdens of illness, and the anticipated  
2 recipient needs in order to maintain good health.

3 3. [If the department implements a utilization threshold program, at a  
4 minimum, such program must include:

5 (a) prior notice to the recipients affected by the utilization thresh-  
6 old program, which notice must describe:

7 (i) the nature and extent of the utilization program, the procedures  
8 for obtaining an exemption from or increase in a utilization threshold,  
9 the recipients' fair hearing rights, and referral to an informational  
10 toll-free hot-line operated by the department; and

11 (ii) alternatives to the utilization threshold program such as enroll-  
12 ment in managed care programs and referral to preferred primary care  
13 providers designated pursuant to subdivision twelve of section twenty-  
14 eight hundred seven of the public health law; and

15 (b) procedures for:

16 (i) requesting an increase in amount of authorized services;

17 (ii) extending amount of authorized services when an application for  
18 an increase in the amount of authorized services is pending;

19 (iii) requesting an exemption from utilization thresholds, which  
20 procedure must:

21 (A) allow the recipient, or a provider on behalf of a recipient, to  
22 apply to the department for an exemption from one or more utilization  
23 thresholds based upon documentation of the medical necessity for  
24 services in excess of the threshold,

25 (B) provided for exemptions consistent with department guidelines for  
26 approving exemptions, which guidelines must be established by the  
27 department in consultation with the department of health and, as appro-  
28 priate, with the department of mental hygiene, and consistent with the

1 current regulations of the office of mental health governing outpatient  
2 treatment.

3 (C) provide for an exemption when medical and clinical documentation  
4 substantiates a condition of a chronic medical nature which requires  
5 ongoing and frequent use of medical care, services or supplies such that  
6 an increase in the amount of authorized services is not sufficient to  
7 meet the medical needs of the recipient;

8 (iv) reimbursing a provider, regardless of the recipient's previous  
9 use of services, when care, services or supplies are provided in a case  
10 of urgent medical need, as defined by the department, or when provided  
11 on an emergency basis, as defined by the department;

12 (v) notifying recipients of and referring recipients to appropriate  
13 and accessible managed care programs and to preferred primary care  
14 providers designated pursuant to subdivision twelve of section twenty-  
15 eight hundred seven of the public health law at the same time such  
16 recipients are notified that they are nearing or have reached the utili-  
17 zation threshold for each specific provider type;

18 (vi) notifying recipients at the same time such recipients are noti-  
19 fied that they have received an exemption from a utilization threshold,  
20 an increase in the amount of authorized services, or that they are near-  
21 ing or have reached their utilization threshold, of their possible  
22 eligibility for federal disability benefits and directing such recipi-  
23 ents to their social services district for information and assistance in  
24 securing such benefits;

25 (vii) cooperating with social services districts in sharing informa-  
26 tion collected and developed by the department regarding recipients'  
27 medical records; and

1 (viii) assuring that no request for an increase in amount of author-  
2 ized services or for an exemption from utilization thresholds shall be  
3 denied unless the request is first reviewed by a health care profes-  
4 sional possessing appropriate clinical expertise.

5 4.] The utilization [thresholds] review established pursuant to this  
6 section shall not apply to [mental retardation and] developmental disa-  
7 bilities services provided in clinics certified under article twenty-  
8 eight of the public health law, or article twenty-two or article thir-  
9 ty-one of the mental hygiene law.

10 [5.] 4. Utilization [thresholds] review established pursuant to this  
11 section shall not apply to services, even though such services might  
12 otherwise be subject to utilization [thresholds] review, when provided  
13 as follows:

14 (a) through a managed care program;

15 (b) subject to prior approval or prior authorization;

16 (c) as family planning services;

17 (d) as methadone maintenance services;

18 (e) on a fee-for-services basis to in-patients in general hospitals  
19 certified under article twenty-eight of the public health law or article  
20 thirty-one of the mental hygiene law and residential health care facili-  
21 ties, with the exception of podiatrists' services;

22 (f) for hemodialysis;

23 (g) through or by referral from a preferred primary care provider  
24 designated pursuant to subdivision twelve of section twenty-eight  
25 hundred seven of the public health law;

26 (h) pursuant to a court order; or

27 (i) as a condition of eligibility for any other public program,  
28 including but not limited to public assistance.

1 [6.] 5. The department shall consult with representatives of medical  
2 assistance providers, social services districts, voluntary organizations  
3 that represent or advocate on behalf of recipients, the managed care  
4 advisory council and other state agencies regarding the ongoing opera-  
5 tion of a utilization [threshold] review system.

6 [7.] 6. On or before February first, nineteen hundred ninety-two, the  
7 commissioner shall submit to the governor, the temporary president of  
8 the senate and the speaker of the assembly a report detailing the imple-  
9 mentation of the utilization threshold program and evaluating the  
10 results of establishing utilization thresholds. Such report shall  
11 include, but need not be limited to, a description of the program as  
12 implemented; the number of requests for increases in service above the  
13 threshold amounts by provider and type of service; the number of exten-  
14 sions granted; the number of claims that were submitted for emergency  
15 care or urgent care above the threshold level; the number of recipients  
16 referred to managed care; an estimate of the fiscal savings to the  
17 medical assistance program as a result of the program; recommendations  
18 for medical condition that may be more appropriately served through  
19 managed care programs; and the costs of implementing the program.

20 § 2. This act shall take effect July 1, 2022; provided, however, that:

21 a. the amendments to subdivision 5 of section 365-g of the social  
22 services law made by section one of this act shall not affect the expi-  
23 ration and reversion of paragraphs (f) and (g) of such subdivision  
24 pursuant to subdivision (i-1) of section 79 of chapter 58 of the laws of  
25 2008, as amended; and

26 b. the amendments to subdivision 5 of section 365-g of the social  
27 services law made by section one of this act shall not affect the repeal  
28 of paragraphs (h) and (i) of such subdivision pursuant to subdivision

1 (i-1) of section 79 of part C of chapter 58 of the laws of 2008, as  
2 amended.

3 PART X

4 Section 1. The title heading of title 2-F of article 2 of the public  
5 health law, as added by chapter 757 of the laws of 1992 and as relet-  
6 tered by chapter 443 of the laws of 1993, is amended to read as follows:

7 OFFICE OF [MINORITY] HEALTH EQUITY

8 § 2. Section 240 of the public health law, as added by chapter 757 of  
9 the laws of 1992 and as renumbered by chapter 443 of the laws of 1993,  
10 is amended to read as follows:

11 § 240. Definitions. For the purposes of this article:

12 1. "Underserved populations" shall mean those who have experienced  
13 injustices and disadvantages as a result of their race, ethnicity, sexu-  
14 al orientation, gender identity, gender expression, disability status,  
15 age, and/or socioeconomic status, among others as determined by the  
16 commissioner of health.

17 2. "[Minority] Racially and ethnically diverse area" shall mean a  
18 county with a non-white population of forty percent or more, or the  
19 service area of an agency, corporation, facility or individual providing  
20 medical and/or health services whose non-white population is forty  
21 percent or more.

22 [2. "Minority health care provider" or "minority provider"] 3.  
23 "Provider" shall mean any agency, corporation, facility, or individual  
24 providing medical and/or health care services to [residents of a minori-  
25 ty area] underserved populations.

1 [3.] 4. "Office" shall mean the office of [minority] health equity, as  
2 created pursuant to section two hundred [thirty-eight-a] forty-one of  
3 this [article] title.

4 [4.] 5. "[Minority health] Health equity council" shall mean that  
5 advisory body to the commissioner, created pursuant to the provisions of  
6 section two hundred [thirty-eight-c] forty-three of this [article]  
7 title.

8 6. "Health disparities" shall mean measurable differences in health  
9 status, access to care, and quality of care as determined by race,  
10 ethnicity, sexual orientation, gender identity, a preferred language  
11 other than English, gender expression, disability status, aging popu-  
12 lation, and socioeconomic status.

13 7. "Health equity" shall mean achieving the highest level of health  
14 for all people and shall entail focused efforts to address avoidable  
15 inequalities by equalizing those conditions for health for those that  
16 have experienced injustices, socioeconomic disadvantages, and systemic  
17 disadvantages.

18 8. "Social determinants of health" shall mean life-enhancing  
19 resources, such as availability of healthful foods, quality housing,  
20 economic opportunity, social relationships, transportation, education,  
21 and health care, whose distribution across populations effectively  
22 determines the length and quality of life.

23 § 3. Section 241 of the public health law, as added by chapter 757 of  
24 the laws of 1992 and as renumbered by chapter 443 of the laws of 1993,  
25 is amended to read as follows:

26 § 241. Office of [minority] health equity created. There is hereby  
27 created an office of [minority] health equity within the state depart-  
28 ment of health. Such office shall:

1     1. Work collaboratively with other state agencies and affected stake-  
2 holders, including providers and representatives of underserved popu-  
3 lations, in order to set priorities, collect and disseminate data, and  
4 align resources within the department and across other state agencies.  
5 The office shall also conduct health promotion and educational outreach,  
6 as well as develop and implement interventions aimed at achieving health  
7 equity among underserved populations by implementing strategies to  
8 address the varying complex causes of health disparities, including the  
9 economic, physical, and social environments.

10    2. Integrate and coordinate selected state health care grant and loan  
11 programs established specifically for [minority] promoting health [care  
12 providers and residents] equity in New York state. As part of this func-  
13 tion, the office shall develop a coordinated application process for use  
14 by [minority] providers, municipalities and others in seeking funds  
15 and/or technical assistance on pertinent [minority health care] programs  
16 and services targeted to address health equity among underserved popu-  
17 lations.

18    [2.] 3. Apply for grants, and accept gifts from private and public  
19 sources for research to improve and enhance [minority] health [care  
20 services and facilities] equity. The office shall also promote [minori-  
21 ty] health equity research in universities and colleges.

22    [3.] 4. Together with the [minority] health equity council, serve as  
23 liaison and advocate for the department on [minority] health equity  
24 matters. This function shall include the provision of staff support to  
25 the [minority] health equity council and the establishment of appropri-  
26 ate program linkages with related federal, state, and local agencies and  
27 programs such as the office of [minority] health equity of the public



1 health service, the agricultural extension service and migrant health  
2 services.

3 [4.] 5. Assist medical schools and state agencies to develop compre-  
4 hensive programs to improve [minority] the diversity of health personnel  
5 [supply] workforce by promoting [minority] health equity clinical train-  
6 ing and curriculum improvement, and disseminating [minority] health  
7 career information to high school and college students.

8 [5.] 6. Promote community strategic planning [or new or improved  
9 health care delivery systems and networks in minority areas] to address  
10 the complex causes of health disparities, including the social determi-  
11 nants of health and health care delivery systems and networks, in order  
12 to improve health equity. Strategic network planning and development may  
13 include such considerations as healthful foods, quality housing, econom-  
14 ic opportunity, social relationships, transportation, and education, as  
15 well as health care systems, including associated personnel, capital  
16 facilities, reimbursement, primary care, long-term care, acute care,  
17 rehabilitative, preventive, and related services on the health contin-  
18 uum.

19 [6.] 7. Review the impact of programs, regulations, and [health care  
20 reimbursement] policies on [minority] health [services delivery and  
21 access] equity.

22 § 4. Section 242 of the public health law, as added by chapter 757 of  
23 the laws of 1992 and as renumbered by chapter 443 of the laws of 1993,  
24 is amended to read as follows:

25 § 242. Preparation and distribution of reports. The department shall  
26 submit a biennial report to the governor and the legislature describing  
27 the activities of the office and health status of minority areas. The  
28 first such report shall be transmitted on or before September first,

1 nineteen hundred ninety-four. Such report shall contain the following  
2 information:

3 1. Activities of the office of [minority] health equity, expenditures  
4 incurred in carrying out such activities, and anticipated activities to  
5 be undertaken in the future.

6 2. Progress in carrying out the functions and duties listed in section  
7 two hundred [thirty-eight-a] forty-one of this [article] title.

8 3. An analysis of the health status of [minority citizens] underserved  
9 populations, including those populations within racially and ethnically  
10 diverse areas, and the status of [minority] health delivery systems  
11 servicing those communities. Such analysis shall be conducted in cooper-  
12 ation with the [minority] health equity council and other interested  
13 agencies.

14 4. Any recommended improvements to programs and/or regulations that  
15 would enhance the cost effectiveness of the office, and programs  
16 intended to meet the health and health care needs of [minority citizens]  
17 underserved populations.

18 § 5. Section 243 of the public health law, as added by chapter 757 of  
19 the laws of 1992 and as renumbered by chapter 443 of the laws of 1993,  
20 subdivision 3 as amended by section 55 of part A of chapter 58 of the  
21 laws of 2010, is amended to read as follows:

22 § 243. [Minority health] Health equity council. 1. Appointment of  
23 members. There shall be established in the office of [minority] health  
24 equity a [minority] health equity council to consist of the commissioner  
25 and fourteen members to be appointed by the governor with the advice and  
26 consent of the senate. Membership on the council shall be reflective of  
27 the diversity of the state's population including, but not limited to,  
28 the various [minority] underserved populations throughout the state.

1 2. Terms of office; vacancies. a. [The] Unless specified otherwise in  
2 the bylaws of the health equity council, the terms of office of members  
3 of the [minority] health equity council [shall] may be up to six years.  
4 The members of the health equity council shall continue in office until  
5 the expiration of their terms and until their successors are appointed  
6 and have qualified. Such appointments shall be made by the governor,  
7 with the advice and consent of the senate, within one year following the  
8 expiration of such terms.

9 b. Vacancies shall be filled by appointment by the governor for the  
10 unexpired terms within one year of the date upon which such vacancies  
11 occur. Any vacancy existing on the effective date of paragraph c of this  
12 subdivision shall be filled by appointment within one year of such  
13 effective date.

14 c. In making appointments to the council, the governor shall seek to  
15 ensure that membership on the council reflects the diversity of the  
16 state's population including, but not limited to the various [minority]  
17 underserved populations throughout the state.

18 3. Meetings. a. The [minority] health equity council shall meet as  
19 frequently as its business may require, and at least twice in each year.

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

22 c. A majority of the appointed voting membership of the health equity  
23 council shall constitute a quorum.

24 4. Compensation and expenses. The members of the council shall serve  
25 without compensation other than reimbursement of actual and necessary  
26 expenses.

27 5. Powers and duties. The [minority] health equity council shall, at  
28 the request of the commissioner, consider any matter relating to the

1 preservation and improvement of [minority] health status among the  
2 state's underserved populations, and may advise the commissioner [there-  
3 on; and it may, from time to time, submit to the commissioner,] on any  
4 recommendations relating to the preservation and improvement of [minori-  
5 ty] health equity.

6 § 6. This act shall take effect immediately.

7 PART Y

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

10 § 20-c. Certification of marriage; new certificate in case of subse-  
11 quent change of name or gender. 1. A new marriage certificate shall be  
12 issued by the town or city clerk where the marriage license and certif-  
13 icate was issued, upon receipt of proper proof of a change of name or  
14 gender designation. Proper proof shall consist of: (a) a judgment, order  
15 or decree affirming a change of name or gender designation of either  
16 party to a marriage; (b) an amended birth certificate demonstrating a  
17 change of name or gender designation; or (c) such other proof as may be  
18 established by the commissioner of health.

19 2. On every new marriage certificate made pursuant to this section, a  
20 notation that it is filed pursuant to this section shall be entered  
21 thereon.

22 3. When a new marriage certificate is made pursuant to this section,  
23 the town or city clerk shall substitute such new certificate for the  
24 marriage certificate then on file, if any, and shall send the state  
25 commissioner of health a digital copy of the new marriage certificate in  
26 a format prescribed by the commissioner, with the exception of the city

1 clerk of New York who shall retain their copy. The town or city clerk  
2 shall make a copy of the new marriage certificate for the local record  
3 and hold the contents of the original marriage certificate confidential  
4 along with all supporting documentation, papers and copies pertaining  
5 thereto. It shall not be released or otherwise divulged except by order  
6 of a court of competent jurisdiction.

7 4. The town or city clerk shall be entitled to a fee of ten dollars  
8 for the amendment and certified copy of any marriage certificate in  
9 accordance with the provisions of this section.

10 5. The state commissioner of health may, in their discretion, report  
11 to the attorney general any town or city clerk that, without cause,  
12 fails to issue a new marriage certificate upon receipt of proper proof  
13 of a change of name or gender designation in accordance with this  
14 section. The attorney general shall thereupon, in the name of the state  
15 commissioner of health or the people of the state, institute such action  
16 or proceeding as may be necessary to compel the issuance of such new  
17 marriage certificate.

18 § 2. This act shall take effect one year after it shall have become a  
19 law.

20 PART Z

21 Section 1. Section 18 of chapter 266 of the laws of 1986, amending  
22 the civil practice law and rules and other laws relating to malpractice  
23 and professional medical conduct, is amended by adding a new subdivision  
24 9 to read as follows:

25 (9) This subdivision shall apply only to excess insurance coverage or  
26 equivalent excess coverage for physicians or dentists that is eligible

1 to be paid for from funds available in the hospital excess liability  
2 pool.

3 (a) Notwithstanding any law to the contrary, for any policy period  
4 beginning on or after July 1, 2021, excess coverage shall be purchased  
5 by a physician or dentist directly from a provider of excess insurance  
6 coverage or equivalent excess coverage. At the conclusion of the policy  
7 period the superintendent of financial services and the commissioner of  
8 health or their designee shall, from funds available in the hospital  
9 excess liability pool created pursuant to subdivision 5 of this section,  
10 reimburse fifty percent of the premium to the physician or dentist, and  
11 the remaining fifty percent shall be paid one year thereafter. If the  
12 funds available in the hospital excess liability pool are insufficient  
13 to meet the percent of the costs of the excess coverage, the provisions  
14 of subdivision 8 of this section shall apply.

15 (b) No provider of excess insurance coverage or equivalent excess  
16 coverage shall issue excess coverage to which this subdivision applies  
17 to any physician or dentist unless that physician or dentist meets the  
18 eligibility requirements for such coverage set forth in this section.  
19 The superintendent of financial services and the commissioner of health  
20 or their designee shall not make any payment under this subdivision to a  
21 physician or dentist who does not meet the eligibility requirements for  
22 participation in the hospital excess liability pool program set forth in  
23 this section.

24 (c) The superintendent of financial services in consultation with the  
25 commissioner of health may promulgate regulations giving effect to the  
26 provisions of this subdivision.

27 § 2. Paragraph (a) of subdivision 1 of section 18 of chapter 266 of  
28 the laws of 1986, amending the civil practice law and rules and other

1 laws relating to malpractice and professional medical conduct, as  
2 amended by section 1 of part K of chapter 57 of the laws of 2021, is  
3 amended to read as follows:

4 (a) The superintendent of financial services and the commissioner of  
5 health or their designee shall, from funds available in the hospital  
6 excess liability pool created pursuant to subdivision 5 of this section,  
7 purchase a policy or policies for excess insurance coverage, as author-  
8 ized by paragraph 1 of subsection (e) of section 5502 of the insurance  
9 law; or from an insurer, other than an insurer described in section 5502  
10 of the insurance law, duly authorized to write such coverage and actual-  
11 ly writing medical malpractice insurance in this state; or shall  
12 purchase equivalent excess coverage in a form previously approved by the  
13 superintendent of financial services for purposes of providing equiv-  
14 alent excess coverage in accordance with section 19 of chapter 294 of  
15 the laws of 1985, for medical or dental malpractice occurrences between  
16 July 1, 1986 and June 30, 1987, between July 1, 1987 and June 30, 1988,  
17 between July 1, 1988 and June 30, 1989, between July 1, 1989 and June  
18 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991  
19 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July  
20 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995,  
21 between July 1, 1995 and June 30, 1996, between July 1, 1996 and June  
22 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998  
23 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July  
24 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002,  
25 between July 1, 2002 and June 30, 2003, between July 1, 2003 and June  
26 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005  
27 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July  
28 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009,

1 between July 1, 2009 and June 30, 2010, between July 1, 2010 and June  
2 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012  
3 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July  
4 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016,  
5 between July 1, 2016 and June 30, 2017, between July 1, 2017 and June  
6 30, 2018, between July 1, 2018 and June 30, 2019, between July 1, 2019  
7 and June 30, 2020, between July 1, 2020 and June 30, 2021, [and] between  
8 July 1, 2021 and June 30, 2022, and between July 1, 2022 and June 30,  
9 2023 or reimburse the hospital where the hospital purchases equivalent  
10 excess coverage as defined in subparagraph (i) of paragraph (a) of  
11 subdivision 1-a of this section for medical or dental malpractice occur-  
12 rences between July 1, 1987 and June 30, 1988, between July 1, 1988 and  
13 June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1,  
14 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between  
15 July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994,  
16 between July 1, 1994 and June 30, 1995, between July 1, 1995 and June  
17 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997  
18 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July  
19 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001,  
20 between July 1, 2001 and June 30, 2002, between July 1, 2002 and June  
21 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004  
22 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July  
23 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008,  
24 between July 1, 2008 and June 30, 2009, between July 1, 2009 and June  
25 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011  
26 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July  
27 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015,  
28 between July 1, 2015 and June 30, 2016, between July 1, 2016 and June



1 30, 2017, between July 1, 2017 and June 30, 2018, between July 1, 2018  
2 and June 30, 2019, between July 1, 2019 and June 30, 2020, between July  
3 1, 2020 and June 30, 2021, [and] between July 1, 2021 and June 30, 2022,  
4 and between July 1, 2022 and June 30, 2023 for physicians or dentists  
5 certified as eligible for each such period or periods pursuant to subdi-  
6 vision 2 of this section by a general hospital licensed pursuant to  
7 article 28 of the public health law; provided that no single insurer  
8 shall write more than fifty percent of the total excess premium for a  
9 given policy year; and provided, however, that such eligible physicians  
10 or dentists must have in force an individual policy, from an insurer  
11 licensed in this state of primary malpractice insurance coverage in  
12 amounts of no less than one million three hundred thousand dollars for  
13 each claimant and three million nine hundred thousand dollars for all  
14 claimants under that policy during the period of such excess coverage  
15 for such occurrences or be endorsed as additional insureds under a  
16 hospital professional liability policy which is offered through a volun-  
17 tary attending physician ("channeling") program previously permitted by  
18 the superintendent of financial services during the period of such  
19 excess coverage for such occurrences. During such period, such policy  
20 for excess coverage or such equivalent excess coverage shall, when  
21 combined with the physician's or dentist's primary malpractice insurance  
22 coverage or coverage provided through a voluntary attending physician  
23 ("channeling") program, total an aggregate level of two million three  
24 hundred thousand dollars for each claimant and six million nine hundred  
25 thousand dollars for all claimants from all such policies with respect  
26 to occurrences in each of such years provided, however, if the cost of  
27 primary malpractice insurance coverage in excess of one million dollars,  
28 but below the excess medical malpractice insurance coverage provided

1 pursuant to this act, exceeds the rate of nine percent per annum, then  
2 the required level of primary malpractice insurance coverage in excess  
3 of one million dollars for each claimant shall be in an amount of not  
4 less than the dollar amount of such coverage available at nine percent  
5 per annum; the required level of such coverage for all claimants under  
6 that policy shall be in an amount not less than three times the dollar  
7 amount of coverage for each claimant; and excess coverage, when combined  
8 with such primary malpractice insurance coverage, shall increase the  
9 aggregate level for each claimant by one million dollars and three  
10 million dollars for all claimants; and provided further, that, with  
11 respect to policies of primary medical malpractice coverage that include  
12 occurrences between April 1, 2002 and June 30, 2002, such requirement  
13 that coverage be in amounts no less than one million three hundred thou-  
14 sand dollars for each claimant and three million nine hundred thousand  
15 dollars for all claimants for such occurrences shall be effective April  
16 1, 2002.

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

21 (3) (a) The superintendent of financial services shall determine and  
22 certify to each general hospital and to the commissioner of health the  
23 cost of excess malpractice insurance for medical or dental malpractice  
24 occurrences between July 1, 1986 and June 30, 1987, between July 1, 1988  
25 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July  
26 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992,  
27 between July 1, 1992 and June 30, 1993, between July 1, 1993 and June  
28 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995

1 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July  
2 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999,  
3 between July 1, 1999 and June 30, 2000, between July 1, 2000 and June  
4 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002  
5 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July  
6 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006,  
7 between July 1, 2006 and June 30, 2007, between July 1, 2007 and June  
8 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009  
9 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July  
10 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013,  
11 between July 1, 2013 and June 30, 2014, between July 1, 2014 and June  
12 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016  
13 and June 30, 2017, between July 1, 2017 and June 30, 2018, between July  
14 1, 2018 and June 30, 2019, between July 1, 2019 and June 30, 2020,  
15 between July 1, 2020 and June 30, 2021, [and] between July 1, 2021 and  
16 June 30, 2022, and between July 1, 2022 and June 30, 2023 allocable to  
17 each general hospital for physicians or dentists certified as eligible  
18 for purchase of a policy for excess insurance coverage by such general  
19 hospital in accordance with subdivision 2 of this section, and may amend  
20 such determination and certification as necessary.

21 (b) The superintendent of financial services shall determine and  
22 certify to each general hospital and to the commissioner of health the  
23 cost of excess malpractice insurance or equivalent excess coverage for  
24 medical or dental malpractice occurrences between July 1, 1987 and June  
25 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989  
26 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July  
27 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993,  
28 between July 1, 1993 and June 30, 1994, between July 1, 1994 and June

1 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996  
2 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July  
3 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000,  
4 between July 1, 2000 and June 30, 2001, between July 1, 2001 and June  
5 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003  
6 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July  
7 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007,  
8 between July 1, 2007 and June 30, 2008, between July 1, 2008 and June  
9 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010  
10 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July  
11 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014,  
12 between July 1, 2014 and June 30, 2015, between July 1, 2015 and June  
13 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017  
14 and June 30, 2018, between July 1, 2018 and June 30, 2019, between July  
15 1, 2019 and June 30, 2020, between July 1, 2020 and June 30, 2021, [and]  
16 between July 1, 2021 and June 30, 2022, and between July 1, 2022 and  
17 June 30, 2023 allocable to each general hospital for physicians or  
18 dentists certified as eligible for purchase of a policy for excess  
19 insurance coverage or equivalent excess coverage by such general hospi-  
20 tal in accordance with subdivision 2 of this section, and may amend such  
21 determination and certification as necessary. The superintendent of  
22 financial services shall determine and certify to each general hospital  
23 and to the commissioner of health the ratable share of such cost alloca-  
24 ble to the period July 1, 1987 to December 31, 1987, to the period Janu-  
25 ary 1, 1988 to June 30, 1988, to the period July 1, 1988 to December 31,  
26 1988, to the period January 1, 1989 to June 30, 1989, to the period July  
27 1, 1989 to December 31, 1989, to the period January 1, 1990 to June 30,  
28 1990, to the period July 1, 1990 to December 31, 1990, to the period

1 January 1, 1991 to June 30, 1991, to the period July 1, 1991 to December  
2 31, 1991, to the period January 1, 1992 to June 30, 1992, to the period  
3 July 1, 1992 to December 31, 1992, to the period January 1, 1993 to June  
4 30, 1993, to the period July 1, 1993 to December 31, 1993, to the period  
5 January 1, 1994 to June 30, 1994, to the period July 1, 1994 to December  
6 31, 1994, to the period January 1, 1995 to June 30, 1995, to the period  
7 July 1, 1995 to December 31, 1995, to the period January 1, 1996 to June  
8 30, 1996, to the period July 1, 1996 to December 31, 1996, to the period  
9 January 1, 1997 to June 30, 1997, to the period July 1, 1997 to December  
10 31, 1997, to the period January 1, 1998 to June 30, 1998, to the period  
11 July 1, 1998 to December 31, 1998, to the period January 1, 1999 to June  
12 30, 1999, to the period July 1, 1999 to December 31, 1999, to the period  
13 January 1, 2000 to June 30, 2000, to the period July 1, 2000 to December  
14 31, 2000, to the period January 1, 2001 to June 30, 2001, to the period  
15 July 1, 2001 to June 30, 2002, to the period July 1, 2002 to June 30,  
16 2003, to the period July 1, 2003 to June 30, 2004, to the period July 1,  
17 2004 to June 30, 2005, to the period July 1, 2005 and June 30, 2006, to  
18 the period July 1, 2006 and June 30, 2007, to the period July 1, 2007  
19 and June 30, 2008, to the period July 1, 2008 and June 30, 2009, to the  
20 period July 1, 2009 and June 30, 2010, to the period July 1, 2010 and  
21 June 30, 2011, to the period July 1, 2011 and June 30, 2012, to the  
22 period July 1, 2012 and June 30, 2013, to the period July 1, 2013 and  
23 June 30, 2014, to the period July 1, 2014 and June 30, 2015, to the  
24 period July 1, 2015 and June 30, 2016, to the period July 1, 2016 and  
25 June 30, 2017, to the period July 1, 2017 to June 30, 2018, to the peri-  
26 od July 1, 2018 to June 30, 2019, to the period July 1, 2019 to June 30,  
27 2020, to the period July 1, 2020 to June 30, 2021, [and] to the period

1 July 1, 2021 to June 30, 2022, and to the period July 1, 2022 to June  
2 30, 2023.

3 § 4. Paragraphs (a), (b), (c), (d) and (e) of subdivision 8 of section  
4 18 of chapter 266 of the laws of 1986, amending the civil practice law  
5 and rules and other laws relating to malpractice and professional  
6 medical conduct, as amended by section 3 of part K of chapter 57 of the  
7 laws of 2021, are amended to read as follows:

8 (a) To the extent funds available to the hospital excess liability  
9 pool pursuant to subdivision 5 of this section as amended, and pursuant  
10 to section 6 of part J of chapter 63 of the laws of 2001, as may from  
11 time to time be amended, which amended this subdivision, are insuffi-  
12 cient to meet the costs of excess insurance coverage or equivalent  
13 excess coverage for coverage periods during the period July 1, 1992 to  
14 June 30, 1993, during the period July 1, 1993 to June 30, 1994, during  
15 the period July 1, 1994 to June 30, 1995, during the period July 1, 1995  
16 to June 30, 1996, during the period July 1, 1996 to June 30, 1997,  
17 during the period July 1, 1997 to June 30, 1998, during the period July  
18 1, 1998 to June 30, 1999, during the period July 1, 1999 to June 30,  
19 2000, during the period July 1, 2000 to June 30, 2001, during the period  
20 July 1, 2001 to October 29, 2001, during the period April 1, 2002 to  
21 June 30, 2002, during the period July 1, 2002 to June 30, 2003, during  
22 the period July 1, 2003 to June 30, 2004, during the period July 1, 2004  
23 to June 30, 2005, during the period July 1, 2005 to June 30, 2006,  
24 during the period July 1, 2006 to June 30, 2007, during the period July  
25 1, 2007 to June 30, 2008, during the period July 1, 2008 to June 30,  
26 2009, during the period July 1, 2009 to June 30, 2010, during the period  
27 July 1, 2010 to June 30, 2011, during the period July 1, 2011 to June  
28 30, 2012, during the period July 1, 2012 to June 30, 2013, during the

1 period July 1, 2013 to June 30, 2014, during the period July 1, 2014 to  
2 June 30, 2015, during the period July 1, 2015 to June 30, 2016, during  
3 the period July 1, 2016 to June 30, 2017, during the period July 1, 2017  
4 to June 30, 2018, during the period July 1, 2018 to June 30, 2019,  
5 during the period July 1, 2019 to June 30, 2020, during the period July  
6 1, 2020 to June 30, 2021, [and] during the period July 1, 2021 to June  
7 30, 2022, and during the period July 1, 2022 to June 30, 2023 allocated  
8 or reallocated in accordance with paragraph (a) of subdivision 4-a of  
9 this section to rates of payment applicable to state governmental agen-  
10 cies, each physician or dentist for whom a policy for excess insurance  
11 coverage or equivalent excess coverage is purchased for such period  
12 shall be responsible for payment to the provider of excess insurance  
13 coverage or equivalent excess coverage of an allocable share of such  
14 insufficiency, based on the ratio of the total cost of such coverage for  
15 such physician to the sum of the total cost of such coverage for all  
16 physicians applied to such insufficiency.

17 (b) Each provider of excess insurance coverage or equivalent excess  
18 coverage covering the period July 1, 1992 to June 30, 1993, or covering  
19 the period July 1, 1993 to June 30, 1994, or covering the period July 1,  
20 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30,  
21 1996, or covering the period July 1, 1996 to June 30, 1997, or covering  
22 the period July 1, 1997 to June 30, 1998, or covering the period July 1,  
23 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30,  
24 2000, or covering the period July 1, 2000 to June 30, 2001, or covering  
25 the period July 1, 2001 to October 29, 2001, or covering the period  
26 April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to  
27 June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or  
28 covering the period July 1, 2004 to June 30, 2005, or covering the peri-

1 od July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to  
2 June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or  
3 covering the period July 1, 2008 to June 30, 2009, or covering the peri-  
4 od July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to  
5 June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or  
6 covering the period July 1, 2012 to June 30, 2013, or covering the peri-  
7 od July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to  
8 June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or  
9 covering the period July 1, 2016 to June 30, 2017, or covering the peri-  
10 od July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to  
11 June 30, 2019, or covering the period July 1, 2019 to June 30, 2020, or  
12 covering the period July 1, 2020 to June 30, 2021, or covering the peri-  
13 od July 1, 2021 to June 30, 2022, or covering the period July 1, 2022 to  
14 June 30, 2023 shall notify a covered physician or dentist by mail,  
15 mailed to the address shown on the last application for excess insurance  
16 coverage or equivalent excess coverage, of the amount due to such  
17 provider from such physician or dentist for such coverage period deter-  
18 mined in accordance with paragraph (a) of this subdivision. Such amount  
19 shall be due from such physician or dentist to such provider of excess  
20 insurance coverage or equivalent excess coverage in a time and manner  
21 determined by the superintendent of financial services.

22 (c) If a physician or dentist liable for payment of a portion of the  
23 costs of excess insurance coverage or equivalent excess coverage cover-  
24 ing the period July 1, 1992 to June 30, 1993, or covering the period  
25 July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to  
26 June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or  
27 covering the period July 1, 1996 to June 30, 1997, or covering the peri-  
28 od July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to



1 June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or  
2 covering the period July 1, 2000 to June 30, 2001, or covering the peri-  
3 od July 1, 2001 to October 29, 2001, or covering the period April 1,  
4 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30,  
5 2003, or covering the period July 1, 2003 to June 30, 2004, or covering  
6 the period July 1, 2004 to June 30, 2005, or covering the period July 1,  
7 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30,  
8 2007, or covering the period July 1, 2007 to June 30, 2008, or covering  
9 the period July 1, 2008 to June 30, 2009, or covering the period July 1,  
10 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30,  
11 2011, or covering the period July 1, 2011 to June 30, 2012, or covering  
12 the period July 1, 2012 to June 30, 2013, or covering the period July 1,  
13 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30,  
14 2015, or covering the period July 1, 2015 to June 30, 2016, or covering  
15 the period July 1, 2016 to June 30, 2017, or covering the period July 1,  
16 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30,  
17 2019, or covering the period July 1, 2019 to June 30, 2020, or covering  
18 the period July 1, 2020 to June 30, 2021, or covering the period July 1,  
19 2021 to June 30, 2022, or covering the period July 1, 2022 to June 30,  
20 2023 determined in accordance with paragraph (a) of this subdivision  
21 fails, refuses or neglects to make payment to the provider of excess  
22 insurance coverage or equivalent excess coverage in such time and manner  
23 as determined by the superintendent of financial services pursuant to  
24 paragraph (b) of this subdivision, excess insurance coverage or equiv-  
25 alent excess coverage purchased for such physician or dentist in accord-  
26 ance with this section for such coverage period shall be cancelled and  
27 shall be null and void as of the first day on or after the commencement

1 of a policy period where the liability for payment pursuant to this  
2 subdivision has not been met.

3 (d) Each provider of excess insurance coverage or equivalent excess  
4 coverage shall notify the superintendent of financial services and the  
5 commissioner of health or their designee of each physician and dentist  
6 eligible for purchase of a policy for excess insurance coverage or  
7 equivalent excess coverage covering the period July 1, 1992 to June 30,  
8 1993, or covering the period July 1, 1993 to June 30, 1994, or covering  
9 the period July 1, 1994 to June 30, 1995, or covering the period July 1,  
10 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30,  
11 1997, or covering the period July 1, 1997 to June 30, 1998, or covering  
12 the period July 1, 1998 to June 30, 1999, or covering the period July 1,  
13 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30,  
14 2001, or covering the period July 1, 2001 to October 29, 2001, or cover-  
15 ing the period April 1, 2002 to June 30, 2002, or covering the period  
16 July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to  
17 June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or  
18 covering the period July 1, 2005 to June 30, 2006, or covering the peri-  
19 od July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to  
20 June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or  
21 covering the period July 1, 2009 to June 30, 2010, or covering the peri-  
22 od July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to  
23 June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or  
24 covering the period July 1, 2013 to June 30, 2014, or covering the peri-  
25 od July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to  
26 June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or  
27 covering the period July 1, 2017 to June 30, 2018, or covering the peri-  
28 od July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to

1 June 30, 2020, or covering the period July 1, 2020 to June 30, 2021, or  
2 covering the period July 1, 2021 to June 30, 2022, or covering the peri-  
3 od July 1, 2022 to June 1, 2023 that has made payment to such provider  
4 of excess insurance coverage or equivalent excess coverage in accordance  
5 with paragraph (b) of this subdivision and of each physician and dentist  
6 who has failed, refused or neglected to make such payment.

7 (e) A provider of excess insurance coverage or equivalent excess  
8 coverage shall refund to the hospital excess liability pool any amount  
9 allocable to the period July 1, 1992 to June 30, 1993, and to the period  
10 July 1, 1993 to June 30, 1994, and to the period July 1, 1994 to June  
11 30, 1995, and to the period July 1, 1995 to June 30, 1996, and to the  
12 period July 1, 1996 to June 30, 1997, and to the period July 1, 1997 to  
13 June 30, 1998, and to the period July 1, 1998 to June 30, 1999, and to  
14 the period July 1, 1999 to June 30, 2000, and to the period July 1, 2000  
15 to June 30, 2001, and to the period July 1, 2001 to October 29, 2001,  
16 and to the period April 1, 2002 to June 30, 2002, and to the period July  
17 1, 2002 to June 30, 2003, and to the period July 1, 2003 to June 30,  
18 2004, and to the period July 1, 2004 to June 30, 2005, and to the period  
19 July 1, 2005 to June 30, 2006, and to the period July 1, 2006 to June  
20 30, 2007, and to the period July 1, 2007 to June 30, 2008, and to the  
21 period July 1, 2008 to June 30, 2009, and to the period July 1, 2009 to  
22 June 30, 2010, and to the period July 1, 2010 to June 30, 2011, and to  
23 the period July 1, 2011 to June 30, 2012, and to the period July 1, 2012  
24 to June 30, 2013, and to the period July 1, 2013 to June 30, 2014, and  
25 to the period July 1, 2014 to June 30, 2015, and to the period July 1,  
26 2015 to June 30, 2016, to the period July 1, 2016 to June 30, 2017, and  
27 to the period July 1, 2017 to June 30, 2018, and to the period July 1,  
28 2018 to June 30, 2019, and to the period July 1, 2019 to June 30, 2020,

1 and to the period July 1, 2020 to June 30, 2021, and to the period July  
2 1, 2021 to June 30, 2022, and to the period July 1, 2022 to June 30,  
3 2023 received from the hospital excess liability pool for purchase of  
4 excess insurance coverage or equivalent excess coverage covering the  
5 period July 1, 1992 to June 30, 1993, and covering the period July 1,  
6 1993 to June 30, 1994, and covering the period July 1, 1994 to June 30,  
7 1995, and covering the period July 1, 1995 to June 30, 1996, and cover-  
8 ing the period July 1, 1996 to June 30, 1997, and covering the period  
9 July 1, 1997 to June 30, 1998, and covering the period July 1, 1998 to  
10 June 30, 1999, and covering the period July 1, 1999 to June 30, 2000,  
11 and covering the period July 1, 2000 to June 30, 2001, and covering the  
12 period July 1, 2001 to October 29, 2001, and covering the period April  
13 1, 2002 to June 30, 2002, and covering the period July 1, 2002 to June  
14 30, 2003, and covering the period July 1, 2003 to June 30, 2004, and  
15 covering the period July 1, 2004 to June 30, 2005, and covering the  
16 period July 1, 2005 to June 30, 2006, and covering the period July 1,  
17 2006 to June 30, 2007, and covering the period July 1, 2007 to June 30,  
18 2008, and covering the period July 1, 2008 to June 30, 2009, and cover-  
19 ing the period July 1, 2009 to June 30, 2010, and covering the period  
20 July 1, 2010 to June 30, 2011, and covering the period July 1, 2011 to  
21 June 30, 2012, and covering the period July 1, 2012 to June 30, 2013,  
22 and covering the period July 1, 2013 to June 30, 2014, and covering the  
23 period July 1, 2014 to June 30, 2015, and covering the period July 1,  
24 2015 to June 30, 2016, and covering the period July 1, 2016 to June 30,  
25 2017, and covering the period July 1, 2017 to June 30, 2018, and cover-  
26 ing the period July 1, 2018 to June 30, 2019, and covering the period  
27 July 1, 2019 to June 30, 2020, and covering the period July 1, 2020 to  
28 June 30, 2021, and covering the period July 1, 2021 to June 30, 2022,

1 and covering the period July 1, 2022 to June 30, 2023 for a physician or  
2 dentist where such excess insurance coverage or equivalent excess cover-  
3 age is cancelled in accordance with paragraph (c) of this subdivision.

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

8 § 40. The superintendent of financial services shall establish rates  
9 for policies providing coverage for physicians and surgeons medical  
10 malpractice for the periods commencing July 1, 1985 and ending June 30,  
11 [2022] 2023; provided, however, that notwithstanding any other provision  
12 of law, the superintendent shall not establish or approve any increase  
13 in rates for the period commencing July 1, 2009 and ending June 30,  
14 2010. The superintendent shall direct insurers to establish segregated  
15 accounts for premiums, payments, reserves and investment income attrib-  
16 utable to such premium periods and shall require periodic reports by the  
17 insurers regarding claims and expenses attributable to such periods to  
18 monitor whether such accounts will be sufficient to meet incurred claims  
19 and expenses. On or after July 1, 1989, the superintendent shall impose  
20 a surcharge on premiums to satisfy a projected deficiency that is  
21 attributable to the premium levels established pursuant to this section  
22 for such periods; provided, however, that such annual surcharge shall  
23 not exceed eight percent of the established rate until July 1, [2022]  
24 2023, at which time and thereafter such surcharge shall not exceed twen-  
25 ty-five percent of the approved adequate rate, and that such annual  
26 surcharges shall continue for such period of time as shall be sufficient  
27 to satisfy such deficiency. The superintendent shall not impose such  
28 surcharge during the period commencing July 1, 2009 and ending June 30,

1 2010. On and after July 1, 1989, the surcharge prescribed by this  
2 section shall be retained by insurers to the extent that they insured  
3 physicians and surgeons during the July 1, 1985 through June 30, [2022]  
4 2023 policy periods; in the event and to the extent physicians and  
5 surgeons were insured by another insurer during such periods, all or a  
6 pro rata share of the surcharge, as the case may be, shall be remitted  
7 to such other insurer in accordance with rules and regulations to be  
8 promulgated by the superintendent. Surcharges collected from physicians  
9 and surgeons who were not insured during such policy periods shall be  
10 apportioned among all insurers in proportion to the premium written by  
11 each insurer during such policy periods; if a physician or surgeon was  
12 insured by an insurer subject to rates established by the superintendent  
13 during such policy periods, and at any time thereafter a hospital,  
14 health maintenance organization, employer or institution is responsible  
15 for responding in damages for liability arising out of such physician's  
16 or surgeon's practice of medicine, such responsible entity shall also  
17 remit to such prior insurer the equivalent amount that would then be  
18 collected as a surcharge if the physician or surgeon had continued to  
19 remain insured by such prior insurer. In the event any insurer that  
20 provided coverage during such policy periods is in liquidation, the  
21 property/casualty insurance security fund shall receive the portion of  
22 surcharges to which the insurer in liquidation would have been entitled.  
23 The surcharges authorized herein shall be deemed to be income earned for  
24 the purposes of section 2303 of the insurance law. The superintendent,  
25 in establishing adequate rates and in determining any projected defi-  
26 ciency pursuant to the requirements of this section and the insurance  
27 law, shall give substantial weight, determined in his discretion and  
28 judgment, to the prospective anticipated effect of any regulations

1 promulgated and laws enacted and the public benefit of stabilizing  
2 malpractice rates and minimizing rate level fluctuation during the peri-  
3 od of time necessary for the development of more reliable statistical  
4 experience as to the efficacy of such laws and regulations affecting  
5 medical, dental or podiatric malpractice enacted or promulgated in 1985,  
6 1986, by this act and at any other time. Notwithstanding any provision  
7 of the insurance law, rates already established and to be established by  
8 the superintendent pursuant to this section are deemed adequate if such  
9 rates would be adequate when taken together with the maximum authorized  
10 annual surcharges to be imposed for a reasonable period of time whether  
11 or not any such annual surcharge has been actually imposed as of the  
12 establishment of such rates.

13 § 6. Section 5 and subdivisions (a) and (e) of section 6 of part J of  
14 chapter 63 of the laws of 2001, amending chapter 266 of the laws of  
15 1986, amending the civil practice law and rules and other laws relating  
16 to malpractice and professional medical conduct, as amended by section 5  
17 of part K of chapter 57 of the laws of 2021, are amended to read as  
18 follows:

19 § 5. The superintendent of financial services and the commissioner of  
20 health shall determine, no later than June 15, 2002, June 15, 2003, June  
21 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008,  
22 June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15,  
23 2013, June 15, 2014, June 15, 2015, June 15, 2016, June 15, 2017, June  
24 15, 2018, June 15, 2019, June 15, 2020, June 15, 2021, [and] June 15,  
25 2022, and June 15, 2023 the amount of funds available in the hospital  
26 excess liability pool, created pursuant to section 18 of chapter 266 of  
27 the laws of 1986, and whether such funds are sufficient for purposes of  
28 purchasing excess insurance coverage for eligible participating physi-

1 cians and dentists during the period July 1, 2001 to June 30, 2002, or  
2 July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July  
3 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1,  
4 2006 to June 30, 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008  
5 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to  
6 June 30, 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June  
7 30, 2013, or July 1, 2013 to June 30, 2014, or July 1, 2014 to June 30,  
8 2015, or July 1, 2015 to June 30, 2016, or July 1, 2016 to June 30,  
9 2017, or July 1, 2017 to June 30, 2018, or July 1, 2018 to June 30,  
10 2019, or July 1, 2019 to June 30, 2020, or July 1, 2020 to June 30,  
11 2021, or July 1, 2021 to June 30, 2022, or July 1, 2022 to June 30, 2023  
12 as applicable.

13 (a) This section shall be effective only upon a determination, pursu-  
14 ant to section five of this act, by the superintendent of financial  
15 services and the commissioner of health, and a certification of such  
16 determination to the state director of the budget, the chair of the  
17 senate committee on finance and the chair of the assembly committee on  
18 ways and means, that the amount of funds in the hospital excess liabil-  
19 ity pool, created pursuant to section 18 of chapter 266 of the laws of  
20 1986, is insufficient for purposes of purchasing excess insurance cover-  
21 age for eligible participating physicians and dentists during the period  
22 July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July  
23 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1,  
24 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007  
25 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to  
26 June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June  
27 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30,  
28 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30,



1 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30,  
2 2018, or July 1, 2018 to June 30, 2019, or July 1, 2019 to June 30,  
3 2020, or July 1, 2020 to June 30, 2021, or July 1, 2021 to June 30,  
4 2022, or July 1, 2022 to June 30, 2023 as applicable.

5 (e) The commissioner of health shall transfer for deposit to the  
6 hospital excess liability pool created pursuant to section 18 of chapter  
7 266 of the laws of 1986 such amounts as directed by the superintendent  
8 of financial services for the purchase of excess liability insurance  
9 coverage for eligible participating physicians and dentists for the  
10 policy year July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30,  
11 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30,  
12 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30,  
13 2007, as applicable, and the cost of administering the hospital excess  
14 liability pool for such applicable policy year, pursuant to the program  
15 established in chapter 266 of the laws of 1986, as amended, no later  
16 than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June  
17 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010,  
18 June 15, 2011, June 15, 2012, June 15, 2013, June 15, 2014, June 15,  
19 2015, June 15, 2016, June 15, 2017, June 15, 2018, June 15, 2019, June  
20 15, 2020, June 15, 2021, [and] June 15, 2022, and June 15, 2023 as  
21 applicable.

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

26 § 20. Notwithstanding any law, rule or regulation to the contrary,  
27 only physicians or dentists who were eligible, and for whom the super-  
28 intendent of financial services and the commissioner of health, or their

1 designee, purchased, with funds available in the hospital excess liabil-  
2 ity pool, a full or partial policy for excess coverage or equivalent  
3 excess coverage for the coverage period ending the thirtieth of June,  
4 two thousand [twenty-one] twenty-two, shall be eligible to apply for  
5 such coverage for the coverage period beginning the first of July, two  
6 thousand [twenty-one] twenty-two; provided, however, if the total number  
7 of physicians or dentists for whom such excess coverage or equivalent  
8 excess coverage was purchased for the policy year ending the thirtieth  
9 of June, two thousand [twenty-one] twenty-two exceeds the total number  
10 of physicians or dentists certified as eligible for the coverage period  
11 beginning the first of July, two thousand [twenty-one] twenty-two, then  
12 the general hospitals may certify additional eligible physicians or  
13 dentists in a number equal to such general hospital's proportional share  
14 of the total number of physicians or dentists for whom excess coverage  
15 or equivalent excess coverage was purchased with funds available in the  
16 hospital excess liability pool as of the thirtieth of June, two thousand  
17 [twenty-one] twenty-two, as applied to the difference between the number  
18 of eligible physicians or dentists for whom a policy for excess coverage  
19 or equivalent excess coverage was purchased for the coverage period  
20 ending the thirtieth of June, two thousand [twenty-one] twenty-two and  
21 the number of such eligible physicians or dentists who have applied for  
22 excess coverage or equivalent excess coverage for the coverage period  
23 beginning the first of July, two thousand [twenty-one] twenty-two.

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

1 Section 1. This act enacts into law major components of legislation  
2 relating to the federal no surprises act and administrative simplifi-  
3 cation. Each component is wholly contained within a Subpart identified  
4 as Subparts A through C. The effective date for each particular  
5 provision contained within such Subpart is set forth in the last section  
6 of such Subpart. Any provision in any section contained within a  
7 Subpart, including the effective date of the Subpart, which makes a  
8 reference to a section "of this act", when used in connection with that  
9 particular component, shall be deemed to mean and refer to the corre-  
10 sponding section of the Subpart in which it is found. Section three of  
11 this act sets forth the general effective date of this act.

12 SUBPART A

13 Section 1. Section 601 of the financial services law, as added by  
14 section 26 of part H of chapter 60 of the laws of 2014, is amended to  
15 read as follows:

16 § 601. Dispute resolution process established. The superintendent  
17 shall establish a dispute resolution process by which a dispute for a  
18 bill for emergency services or a surprise bill may be resolved. The  
19 superintendent shall have the power to grant and revoke certifications  
20 of independent dispute resolution entities to conduct the dispute resol-  
21 ution process. The superintendent shall promulgate regulations estab-  
22 lishing standards for the dispute resolution process, including a proc-  
23 ess for certifying and selecting independent dispute resolution  
24 entities. An independent dispute resolution entity shall use licensed  
25 physicians in active practice in the same or similar specialty as the  
26 physician providing the service that is subject to the dispute resol-

1 ution process of this article for disputes that involve physician  
2 services. To the extent practicable, the physician shall be licensed in  
3 this state. Disputes shall be submitted to an independent dispute  
4 resolution entity within three years of the date the health care plan  
5 made the original payment on the claim that is the subject of the  
6 dispute.

7 § 2. Subsection (b) of section 602 of the financial services law is  
8 REPEALED.

9 § 3. Subsection (h) of section 603 of the financial services law, as  
10 added by section 26 of part H of chapter 60 of the laws of 2014, is  
11 amended to read as follows:

12 (h) "Surprise bill" means a bill for health care services, other than  
13 emergency services, [received by] with respect to:

14 (1) an insured for services rendered by a non-participating [physi-  
15 cian] provider at a participating hospital or ambulatory surgical  
16 center, where a participating [physician] provider is unavailable or a  
17 non-participating [physician] provider renders services without the  
18 insured's knowledge, or unforeseen medical services arise at the time  
19 the health care services are rendered; provided, however, that a  
20 surprise bill shall not mean a bill received for health care services  
21 when a participating [physician] provider is available and the insured  
22 has elected to obtain services from a non-participating [physician]  
23 provider;

24 (2) an insured for services rendered by a non-participating provider,  
25 where the services were referred by a participating physician to a non-  
26 participating provider without explicit written consent of the insured  
27 acknowledging that the participating physician is referring the insured

1 to a non-participating provider and that the referral may result in  
2 costs not covered by the health care plan; or

3 (3) a patient who is not an insured for services rendered by a physi-  
4 cian at a hospital or ambulatory surgical center, where the patient has  
5 not timely received all of the disclosures required pursuant to section  
6 twenty-four of the public health law.

7 § 4. Section 604 of the financial services law, as amended by chapter  
8 377 of the laws of 2019, is amended to read as follows:

9 § 604. Criteria for determining a reasonable fee. In determining the  
10 appropriate amount to pay for a health care service, an independent  
11 dispute resolution entity shall consider all relevant factors, includ-  
12 ing:

13 (a) whether there is a gross disparity between the fee charged by the  
14 [physician or hospital] provider for services rendered as compared to:

15 (1) fees paid to the involved [physician or hospital] provider for the  
16 same services rendered by the [physician or hospital] provider to other  
17 patients in health care plans in which the [physician or hospital]  
18 provider is not participating, and

19 (2) in the case of a dispute involving a health care plan, fees paid  
20 by the health care plan to reimburse similarly qualified [physicians or  
21 hospitals] providers for the same services in the same region who are  
22 not participating with the health care plan;

23 (b) the level of training, education and experience of the [physician]  
24 health care professional, and in the case of a hospital, the teaching  
25 staff, scope of services and case mix;

26 (c) the [physician's and hospital's] provider's usual charge for  
27 comparable services with regard to patients in health care plans in  
28 which the [physician or hospital] provider is not participating;

1 (d) the circumstances and complexity of the particular case, including  
2 time and place of the service;

3 (e) individual patient characteristics; [and, with regard to physician  
4 services,]

5 (f) the median of the rate recognized by the health care plan to reim-  
6 burse similarly qualified providers for the same or similar services in  
7 the same region that are participating with the health care plan; and

8 (g) with regard to physician services, the usual and customary cost of  
9 the service.

10 § 5. Subsections (a) and (c) of section 605 of the financial services  
11 law, as amended by chapter 377 of the laws of 2019, paragraphs 1 and 2  
12 of subsection (a) as amended by section 1 of part YY of chapter 56 of  
13 the laws of 2020, are amended to read as follows:

14 (a) Emergency services for an insured. (1) When a health care plan  
15 receives a bill for emergency services from a non-participating [physi-  
16 cian or hospital] provider, including a bill for inpatient services  
17 which follow an emergency room visit, the health care plan shall pay an  
18 amount that it determines is reasonable for the emergency services,  
19 including inpatient services which follow an emergency room visit,  
20 rendered by the non-participating [physician or hospital] provider, in  
21 accordance with section three thousand two hundred twenty-four-a of the  
22 insurance law, except for the insured's co-payment, coinsurance or  
23 deductible, if any, and shall ensure that the insured shall incur no  
24 greater out-of-pocket costs for the emergency services, including inpa-  
25 tient services which follow an emergency room visit, than the insured  
26 would have incurred with a participating [physician or hospital] provid-  
27 er. [If an insured assigns benefits to a non-participating physician or  
28 hospital in relation to emergency services, including inpatient services

1 which follow an emergency room visit, provided by such non-participating  
2 physician or hospital, the] The non-participating [physician or hospi-  
3 tal] provider may bill the health care plan for the services rendered.  
4 Upon receipt of the bill, the health care plan shall pay the non-parti-  
5 cipating [physician or hospital] provider the amount prescribed by this  
6 section and any subsequent amount determined to be owed to the [physi-  
7 cian or hospital] provider in relation to the emergency services  
8 provided, including inpatient services which follow an emergency room  
9 visit.

10 (2) A non-participating [physician or hospital] provider or a health  
11 care plan may submit a dispute regarding a fee or payment for emergency  
12 services, including inpatient services which follow an emergency room  
13 visit, for review to an independent dispute resolution entity.

14 (3) The independent dispute resolution entity shall make a determi-  
15 nation within thirty business days of receipt of the dispute for review.

16 (4) In determining a reasonable fee for the services rendered, an  
17 independent dispute resolution entity shall select either the health  
18 care plan's payment or the non-participating [physician's or hospital's]  
19 provider's fee. The independent dispute resolution entity shall deter-  
20 mine which amount to select based upon the conditions and factors set  
21 forth in section six hundred four of this article. If an independent  
22 dispute resolution entity determines, based on the health care plan's  
23 payment and the non-participating [physician's or hospital's] provider's  
24 fee, that a settlement between the health care plan and non-participat-  
25 ing [physician or hospital] provider is reasonably likely, or that both  
26 the health care plan's payment and the non-participating [physician's or  
27 hospital's] provider's fee represent unreasonable extremes, then the  
28 independent dispute resolution entity may direct both parties to attempt

1 a good faith negotiation for settlement. The health care plan and non-  
2 participating [physician or hospital] provider may be granted up to ten  
3 business days for this negotiation, which shall run concurrently with  
4 the thirty business day period for dispute resolution.

5 (c) The determination of an independent dispute resolution entity  
6 shall be binding on the health care plan, [physician or hospital]  
7 provider and patient, and shall be admissible in any court proceeding  
8 between the health care plan, [physician or hospital] provider or  
9 patient, or in any administrative proceeding between this state and the  
10 [physician or hospital] provider.

11 § 6. Subsection (d) of section 605 of the financial services law is  
12 REPEALED and subsection (e) of section 605 of the financial services law  
13 is relettered subsection (d).

14 § 7. Section 606 of the financial services law, as amended by section  
15 3 of part YY of chapter 56 of the laws of 2020, is amended to read as  
16 follows:

17 § 606. Hold harmless [and assignment of benefits] for insureds from  
18 bills for emergency services and surprise bills. (a) [When an insured  
19 assigns benefits for a surprise bill in writing to a non-participating  
20 physician that knows the insured is insured under a health care plan,  
21 the] A non-participating [physician] provider shall not bill [the] an  
22 insured for a surprise bill except for any applicable copayment, coinsu-  
23 rance or deductible that would be owed if the insured utilized a partic-  
24 ipating [physician] provider.

25 (b) [When an insured assigns benefits for emergency services, includ-  
26 ing inpatient services which follow an emergency room visit, to a non-  
27 participating physician or hospital that knows the insured is insured  
28 under a health care plan, the] A non-participating [physician or hospi-



1 tal] provider shall not bill [the] an insured for emergency services,  
2 including inpatient services which follow an emergency room visit,  
3 except for any applicable copayment, coinsurance or deductible that  
4 would be owed if the insured utilized a participating [physician or  
5 hospital] provider.

6 § 8. Subsections (a), (b) and (c) of section 607 of the financial  
7 services law, as added by section 26 of part H of chapter 60 of the laws  
8 of 2014, are amended to read as follows:

9 (a) Surprise bill [received by] involving an insured [who assigns  
10 benefits]. (1) [If] For a surprise bill involving an insured [assigns  
11 benefits to a non-participating physician], the health care plan shall  
12 pay the non-participating [physician] provider in accordance with para-  
13 graphs two and three of this subsection.

14 (2) The non-participating [physician] provider may bill the health  
15 care plan for the health care services rendered, and the health care  
16 plan shall pay the non-participating [physician] provider the billed  
17 amount or attempt to negotiate reimbursement with the non-participating  
18 [physician] provider.

19 (3) If the health care plan's attempts to negotiate reimbursement for  
20 health care services provided by a non-participating [physician] provid-  
21 er does not result in a resolution of the payment dispute between the  
22 non-participating [physician] provider and the health care plan, the  
23 health care plan shall pay the non-participating [physician] provider an  
24 amount the health care plan determines is reasonable for the health care  
25 services rendered, except for the insured's copayment, coinsurance or  
26 deductible, in accordance with section three thousand two hundred twen-  
27 ty-four-a of the insurance law, and shall ensure that the insured shall

1 incur no greater out-of-pocket costs for the surprise bill than the  
2 insured would have incurred with a participating provider.

3 (4) Either the health care plan or the non-participating [physician]  
4 provider may submit the dispute regarding the surprise bill for review  
5 to an independent dispute resolution entity, provided however, the  
6 health care plan may not submit the dispute unless it has complied with  
7 the requirements of paragraphs one, two and three of this subsection.

8 (5) The independent dispute resolution entity shall make a determi-  
9 nation within thirty business days of receipt of the dispute for review.

10 (6) When determining a reasonable fee for the services rendered, the  
11 independent dispute resolution entity shall select either the health  
12 care plan's payment or the non-participating [physician's] provider's  
13 fee. An independent dispute resolution entity shall determine which  
14 amount to select based upon the conditions and factors set forth in  
15 section six hundred four of this article. If an independent dispute  
16 resolution entity determines, based on the health care plan's payment  
17 and the non-participating [physician's] provider's fee, that a settle-  
18 ment between the health care plan and non-participating [physician]  
19 provider is reasonably likely, or that both the health care plan's  
20 payment and the non-participating [physician's] provider's fee represent  
21 unreasonable extremes, then the independent dispute resolution entity  
22 may direct both parties to attempt a good faith negotiation for settle-  
23 ment. The health care plan and non-participating [physician] provider  
24 may be granted up to ten business days for this negotiation, which shall  
25 run concurrently with the thirty business day period for dispute resol-  
26 ution.

27 (b) Surprise bill received by [an insured who does not assign benefits  
28 or by] a patient who is not an insured.

1 (1) [An insured who does not assign benefits in accordance with  
2 subsection (a) of this section or a] A patient who is not an insured and  
3 who receives a surprise bill may submit a dispute regarding the surprise  
4 bill for review to an independent dispute resolution entity.

5 (2) The independent dispute resolution entity shall determine a  
6 reasonable fee for the services rendered based upon the conditions and  
7 factors set forth in section six hundred four of this article.

8 (3) A patient [or insured who does not assign benefits in accordance  
9 with subsection (a) of this section] shall not be required to pay the  
10 physician's fee to be eligible to submit the dispute for review to the  
11 independent dispute resolution entity.

12 (c) The determination of an independent dispute resolution entity  
13 shall be binding on the patient, [physician] provider and health care  
14 plan, and shall be admissible in any court proceeding between the  
15 patient or insured, [physician] provider or health care plan, or in any  
16 administrative proceeding between this state and the [physician] provid-  
17 er.

18 § 9. Subsection (a) of section 608 of the financial services law, as  
19 amended by chapter 375 of the laws of 2019, is amended to read as  
20 follows:

21 (a) For disputes involving an insured, when the independent dispute  
22 resolution entity determines the health care plan's payment is reason-  
23 able, payment for the dispute resolution process shall be the responsi-  
24 bility of the non-participating [physician or hospital] provider. When  
25 the independent dispute resolution entity determines the non-participat-  
26 ing [physician's or hospital's] provider's fee is reasonable, payment  
27 for the dispute resolution process shall be the responsibility of the  
28 health care plan. When a good faith negotiation directed by the inde-

1 pendent dispute resolution entity pursuant to paragraph four of  
2 subsection (a) of section six hundred five of this article, or paragraph  
3 six of subsection (a) of section six hundred seven of this article  
4 results in a settlement between the health care plan and non-participat-  
5 ing [physician or hospital] provider, the health care plan and the non-  
6 participating [physician or hospital] provider shall evenly divide and  
7 share the prorated cost for dispute resolution.

8 § 10. Subparagraph (A) of paragraph 1 of subsection (b) of section  
9 4910 of the insurance law, as amended by chapter 219 of the laws of  
10 2011, is amended to read as follows:

11 (A) the insured has had coverage of the health care service, which  
12 would otherwise be a covered benefit under a subscriber contract or  
13 governmental health benefit program, denied on appeal, in whole or in  
14 part, pursuant to title one of this article on the grounds that such  
15 health care service does not meet the health care plan's requirements  
16 for medical necessity, appropriateness, health care setting, level of  
17 care, [or] effectiveness of a covered benefit, or other ground consist-  
18 ent with 42 U.S.C. § 300gg-19 as determined by the superintendent, and

19 § 11. Subparagraph (i) of paragraph (a) of subdivision 2 of section  
20 4910 of the public health law, as amended by chapter 219 of the laws of  
21 2011, is amended to read as follows:

22 (i) the enrollee has had coverage of a health care service, which  
23 would otherwise be a covered benefit under a subscriber contract or  
24 governmental health benefit program, denied on appeal, in whole or in  
25 part, pursuant to title one of this article on the grounds that such  
26 health care service does not meet the health care plan's requirements  
27 for medical necessity, appropriateness, health care setting, level of  
28 care, [or] effectiveness of a covered benefit, or other ground consist-

1 ent with 42 U.S.C. § 300gg-19 as determined by the commissioner in  
2 consultation with the superintendent of financial services, and  
3 § 12. This act shall take effect immediately.

4 SUBPART B

5 Section 1. Paragraph 1 of subsection (c) of section 109 of the insur-  
6 ance law, as amended by section 55 of part A of chapter 62 of the laws  
7 of 2011, is amended to read as follows:

8 (1) If the superintendent finds after notice and hearing that any  
9 authorized insurer, representative of the insurer, licensed insurance  
10 agent, licensed insurance broker, licensed adjuster, or any other person  
11 or entity licensed, certified, registered, or authorized pursuant to  
12 this chapter, has [wilfully] willfully violated the provisions of this  
13 chapter or any regulation promulgated thereunder or with respect to  
14 accident and health insurance, any provision of federal law or regu-  
15 lation, then the superintendent may order the person or entity to pay to  
16 the people of this state a penalty in a sum not exceeding one thousand  
17 dollars for each offense.

18 § 2. Paragraph 17 of subsection (a) of section 3217-a of the insur-  
19 ance law, as amended by section 9 of subpart A of part BB of chapter 57  
20 of the laws of 2019, is amended to read as follows:

21 (17) where applicable, a listing by specialty, which may be in a sepa-  
22 rate document that is updated annually, of the name, address, [and]  
23 telephone number, and digital contact information of all participating  
24 providers, including facilities, and: (A) whether the provider is  
25 accepting new patients; (B) in the case of mental health or substance  
26 use disorder services providers, any affiliations with participating

1 facilities certified or authorized by the office of mental health or the  
2 office of [alcoholism] addiction services and [substance abuse services]  
3 supports, and any restrictions regarding the availability of the indi-  
4 vidual provider's services; and (C) in the case of physicians, board  
5 certification, languages spoken and any affiliations with participating  
6 hospitals. The listing shall also be posted on the insurer's website and  
7 the insurer shall update the website within fifteen days of the addition  
8 or termination of a provider from the insurer's network or a change in a  
9 physician's hospital affiliation;

10 § 3. Section 3217-b of the insurance law is amended by adding two new  
11 subsections (m) and (n) to read as follows:

12 (m) A contract between an insurer and a health care provider shall  
13 include a provision that requires the health care provider to have in  
14 place business processes to ensure the timely provision of provider  
15 directory information to the insurer. A health care provider shall  
16 submit such provider directory information to an insurer, at a minimum,  
17 when a provider begins or terminates a network agreement with an insur-  
18 er, when there are material changes to the content of the provider  
19 directory information of the health care provider, and at any other  
20 time, including upon the insurer's request, as the health care provider  
21 determines to be appropriate. For purposes of this subsection, "provid-  
22 er directory information" shall include the name, address, specialty,  
23 telephone number, and digital contact information of such health care  
24 provider; whether the provider is accepting new patients; for mental  
25 health and substance use disorder services providers, any affiliations  
26 with participating facilities certified or authorized by the office of  
27 mental health or the office of addiction services and supports, and any  
28 restrictions regarding the availability of the individual provider's

1 services; and in the case of physicians, board certification, languages  
2 spoken, and any affiliations with participating hospitals.

3 (n) A contract between an insurer and a health care provider shall  
4 include a provision that states that the provider shall reimburse the  
5 insured for the full amount paid by the insured in excess of the in-net-  
6 work cost-sharing amount, plus interest at an interest rate determined  
7 by the superintendent in accordance with 42 U.S.C. § 300gg-139(b), for  
8 the services involved when the insured is provided with inaccurate  
9 network status information by the insurer in a provider directory or in  
10 response to a request that stated that the provider was a participating  
11 provider when the provider was not a participating provider. Nothing in  
12 this subsection shall prohibit a health care provider from requiring in  
13 the terms of a contract with an insurer that the insurer remove, at the  
14 time of termination of such contract, the provider from the insurer's  
15 provider directory or that the insurer bear financial responsibility for  
16 providing inaccurate network status information to an insured.

17 § 4. Paragraph 17 of subsection (a) of section 4324 of the insurance  
18 law, as amended by section 34 of subpart A of part BB of chapter 57 of  
19 the laws of 2019, is amended to read as follows:

20 (17) where applicable, a listing by specialty, which may be in a sepa-  
21 rate document that is updated annually, of the name, address, [and]  
22 telephone number, and digital contact information of all participating  
23 providers, including facilities, and: (A) whether the provider is  
24 accepting new patients; (B) in the case of mental health or substance  
25 use disorder services providers, any affiliations with participating  
26 facilities certified or authorized by the office of mental health or the  
27 office of [alcoholism] addiction services and [substance abuse services]  
28 supports, and any restrictions regarding the availability of the indi-

1 vidual provider's services; (C) in the case of physicians, board certifi-  
2 cation, languages spoken and any affiliations with participating hospi-  
3 tals. The listing shall also be posted on the corporation's website and  
4 the corporation shall update the website within fifteen days of the  
5 addition or termination of a provider from the corporation's network or  
6 a change in a physician's hospital affiliation;

7 § 5. Section 4325 of the insurance law is amended by adding two new  
8 subsections (n) and (o) to read as follows:

9 (n) A contract between a corporation and a health care provider shall  
10 include a provision that requires the health care provider to have in  
11 place business processes to ensure the timely provision of provider  
12 directory information to the corporation. A health care provider shall  
13 submit such provider directory information to a corporation, at a mini-  
14 mum, when a provider begins or terminates a network agreement with a  
15 corporation, when there are material changes to the content of the  
16 provider directory information of the health care provider, and at any  
17 other time, including upon the corporation's request, as the health care  
18 provider determines to be appropriate. For purposes of this subsection,  
19 "provider directory information" shall include the name, address,  
20 specialty, telephone number, and digital contact information of such  
21 health care provider; whether the provider is accepting new patients;  
22 for mental health and substance use disorder services providers, any  
23 affiliations with participating facilities certified or authorized by  
24 the office of mental health or the office of addiction services and  
25 supports, and any restrictions regarding the availability of the indi-  
26 vidual provider's services; and in the case of physicians, board certifi-  
27 cation, languages spoken, and any affiliations with participating  
28 hospitals.



1 (o) A contract between a corporation and a health care provider shall  
2 include a provision that states that the provider shall reimburse the  
3 insured for the full amount paid by the insured in excess of the in-net-  
4 work cost-sharing amount, plus interest at an interest rate determined  
5 by the superintendent in accordance with 42 U.S.C. § 300gg-139(b), for  
6 the services involved when the insured is provided with inaccurate  
7 network status information by the corporation in a provider directory or  
8 in response to a request that stated that the provider was a participat-  
9 ing provider when the provider was not a participating provider. Noth-  
10 ing in this subsection shall prohibit a health care provider from  
11 requiring in the terms of a contract with a corporation that the corpo-  
12 ration remove, at the time of termination of such contract, the provider  
13 from the corporation's provider directory or that the corporation bear  
14 financial responsibility for providing inaccurate network status infor-  
15 mation to an insured.

16 § 6. Section 4406-c of the public health law is amended by adding two  
17 new subdivisions 11 and 12 to read as follows:

18 11. A contract between a health care plan and a health care provider  
19 shall include a provision that requires the health care provider to have  
20 in place business processes to ensure the timely provision of provider  
21 directory information to the health care plan. A health care provider  
22 shall submit such provider directory information to a health care plan,  
23 at a minimum, when a provider begins or terminates a network agreement  
24 with a health care plan, when there are material changes to the content  
25 of the provider directory information of such health care provider, and  
26 at any other time, including upon the health care plan's request, as the  
27 health care provider determines to be appropriate. For purposes of this  
28 subsection, "provider directory information" shall include the name,

1 address, specialty, telephone number, and digital contact information of  
2 such health care provider; whether the provider is accepting new  
3 patients; for mental health and substance use disorder services provid-  
4 ers, any affiliations with participating facilities certified or author-  
5 ized by the office of mental health or the office of addiction services  
6 and supports, and any restrictions regarding the availability of the  
7 individual provider's services; and in the case of physicians, board  
8 certification, languages spoken, and any affiliations with participating  
9 hospitals.

10 12. A contract between a health care plan and a health care provider  
11 shall include a provision that states that the provider shall reimburse  
12 the enrollee for the full amount paid by the enrollee in excess of the  
13 in-network cost-sharing amount, plus interest at an interest rate deter-  
14 mined by the commissioner in accordance with 42 U.S.C. § 300gg-139(b),  
15 for the services involved when the enrollee is provided with inaccurate  
16 network status information by the health care plan in a provider direc-  
17 tory or in response to a request that stated that the provider was a  
18 participating provider when the provider was not a participating provid-  
19 er. Nothing in this subdivision shall prohibit a health care provider  
20 from requiring in the terms of a contract with a health care plan that  
21 the health care plan remove, at the time of termination of such  
22 contract, the provider from the health care plan's provider directory or  
23 that the health care plan bear financial responsibility for providing  
24 inaccurate network status information to an enrollee.

25 § 7. Paragraph (r) of subdivision 1 of section 4408 of the public  
26 health law, as amended by section 41 of subpart A of part BB of chapter  
27 57 of the laws of 2019, is amended to read as follows:

1 (r) a listing by specialty, which may be in a separate document that  
2 is updated annually, of the name, address [and], telephone number, and  
3 digital contact information of all participating providers, including  
4 facilities, and: (i) whether the provider is accepting new patients;  
5 (ii) in the case of mental health or substance use disorder services  
6 providers, any affiliations with participating facilities certified or  
7 authorized by the office of mental health or the office of [alcoholism]  
8 addiction services and [substance abuse services] supports, and any  
9 restrictions regarding the availability of the individual provider's  
10 services; and (iii) in the case of physicians, board certification,  
11 languages spoken and any affiliations with participating hospitals. The  
12 listing shall also be posted on the health maintenance organization's  
13 website and the health maintenance organization shall update the website  
14 within fifteen days of the addition or termination of a provider from  
15 the health maintenance organization's network or a change in a physi-  
16 cian's hospital affiliation;

17 § 8. Subdivision 8 of section 24 of the public health law is renum-  
18 bered subdivision 9 and a new subdivision 8 is added to read as follows:

19 8. A health care professional, or a group practice of health care  
20 professionals, a diagnostic and treatment center or a health center  
21 defined under 42 U.S.C. § 254b on behalf of health care professionals  
22 rendering services at the group practice, diagnostic and treatment  
23 center or health center, and a hospital shall make publicly available,  
24 and if applicable, post on their public websites, and provide to indi-  
25 viduals who are enrollees of health care plans, a one-page written  
26 notice, in clear and understandable language, containing information on  
27 the requirements and prohibitions under 42 U.S.C. §§ 300gg-131 and  
28 300gg-132 and article six of the financial services law relating to

1 prohibitions on balance billing for emergency services and surprise  
2 bills, and information on contacting appropriate state and federal agen-  
3 cies if an individual believes a health care provider has violated any  
4 requirement described in 42 U.S.C. §§ 300gg-131 and 300gg-132 or article  
5 six of the financial services law.

6 § 9. Subsection (e) of section 4804 of the insurance law, as added by  
7 chapter 705 of the laws of 1996, is amended to read as follows:

8 (e) (1) If an insured's health care provider leaves the insurer's  
9 in-network benefits portion of its network of providers for a managed  
10 care product for reasons other than those for which the provider would  
11 not be eligible to receive a hearing pursuant to paragraph one of  
12 subsection (b) of section forty-eight hundred three of this chapter, the  
13 insurer shall provide written notice to the insured of the provider's  
14 disaffiliation and permit the insured to continue an ongoing course of  
15 treatment with the insured's current health care provider during a tran-  
16 sitional period of [(i) up to]: (A) ninety days from the later of the  
17 date of the notice to the insured of the provider's disaffiliation from  
18 the insurer's network or the effective date of the provider's disaffil-  
19 iation from the insurer's network; or [(ii)] (B) if the insured [has  
20 entered the second trimester of pregnancy] is pregnant at the time of  
21 the provider's disaffiliation, [for a transitional period that includes]  
22 the [provision of] duration of the pregnancy and post-partum care  
23 directly related to the delivery.

24 (2) [Notwithstanding the provisions of paragraph one of this  
25 subsection, such care shall be authorized by the insurer during] During  
26 the transitional period [only if] the health care provider [agrees (i)  
27 to] shall: (A) continue to accept reimbursement from the insurer at the  
28 rates applicable prior to the start of the transitional period, and

1 continue to accept the in-network cost-sharing from the insured, if any,  
2 as payment in full; [(ii) to] (B) adhere to the insurer's quality assur-  
3 ance requirements and [to] provide to the insurer necessary medical  
4 information related to such care; and [(iii) to] (C) otherwise adhere to  
5 the insurer's policies and procedures including, but not limited to,  
6 procedures regarding referrals and obtaining pre-authorization and a  
7 treatment plan approved by the insurer.

8 § 10. Paragraph (e) of subdivision 6 of section 4403 of the public  
9 health law, as added by chapter 705 of the laws of 1996, is amended to  
10 read as follows:

11 (e) (1) If an enrollee's health care provider leaves the health main-  
12 tenance organization's network of providers for reasons other than those  
13 for which the provider would not be eligible to receive a hearing pursu-  
14 ant to paragraph a of subdivision two of section forty-four hundred  
15 six-d of this chapter, the health maintenance organization shall provide  
16 written notice to the enrollee of the provider's disaffiliation and  
17 permit the enrollee to continue an ongoing course of treatment with the  
18 enrollee's current health care provider during a transitional period of:

19 (i) [up to] ninety days from the later of the date of the notice to the  
20 enrollee of the provider's disaffiliation from the organization's  
21 network or the effective date of the provider's disaffiliation from the  
22 organization's network; or (ii) if the enrollee [has entered the second  
23 trimester of pregnancy] is pregnant at the time of the provider's disaf-  
24 filiation, [for a transitional period that includes] the [provision of]  
25 duration of the pregnancy and post-partum care directly related to the  
26 delivery.

27 (2) [Notwithstanding the provisions of subparagraph one of this para-  
28 graph, such care shall be authorized by the health maintenance organiza-

1 tion during] During the transitional period [only if] the health care  
2 provider [agrees] shall: (i) [to] continue to accept reimbursement from  
3 the health maintenance organization at the rates applicable prior to the  
4 start of the transitional period, and continue to accept the in-network  
5 cost-sharing from the enrollee, if any, as payment in full; (ii) [to]  
6 adhere to the organization's quality assurance requirements and to  
7 provide to the organization necessary medical information related to  
8 such care; and (iii) [to] otherwise adhere to the organization's poli-  
9 cies and procedures, including but not limited to procedures regarding  
10 referrals and obtaining pre-authorization and a treatment plan approved  
11 by the organization.

12 § 11. This act shall take effect immediately.

13 SUBPART C

14 Section 1. Section 3217-d of the insurance law is amended by adding a  
15 new subsection (e) to read as follows:

16 (e) An insurer that issues a comprehensive policy that uses a network  
17 of providers and is not a managed care health insurance contract, as  
18 defined in subsection (c) of section four thousand eight hundred one of  
19 this chapter, shall establish and maintain procedures for health care  
20 professional applications and terminations consistent with the require-  
21 ments of section four thousand eight hundred three of this chapter and  
22 procedures for health care facility applications consistent with section  
23 four thousand eight hundred six of this chapter.

24 § 2. Section 4306-c of the insurance law is amended by adding a new  
25 subsection (e) to read as follows:

1 (e) A corporation, including a municipal cooperative health benefit  
2 plan certified pursuant to article forty-seven of this chapter and a  
3 student health plan established or maintained pursuant to section one  
4 thousand one hundred twenty-four of this chapter as added by chapter 246  
5 of the laws of 2012, that issues a comprehensive policy that uses a  
6 network of providers and is not a managed care health insurance  
7 contract, as defined in subsection (c) of section four thousand eight  
8 hundred one of this chapter, shall establish and maintain procedures for  
9 health care professional applications and terminations consistent with  
10 the requirements of section four thousand eight hundred three of this  
11 chapter and procedures for health care facility applications consistent  
12 with section four thousand eight hundred six of this chapter.

13 § 3. The insurance law is amended by adding a new section 4806 to read  
14 as follows:

15 § 4806. Health care facility applications. (a) An insurer that offers  
16 a managed care product shall, upon request, make available and disclose  
17 to facilities written application procedures and minimum qualification  
18 requirements that a facility must meet in order to be considered by the  
19 insurer for participation in the in-network benefits portion of the  
20 insurer's network for the managed care product. The insurer shall  
21 consult with appropriately qualified facilities in developing its quali-  
22 fication requirements for participation in the in-network benefits  
23 portion of the insurer's network for the managed care product. An  
24 insurer shall complete review of the facility's application to partic-  
25 ipate in the in-network portion of the insurer's network and, within  
26 sixty days of receiving a facility's completed application to partic-  
27 ipate in the insurer's network, shall notify the facility as to: (1)  
28 whether the facility is credentialed; or (2) whether additional time is

1 necessary to make a determination because of a failure of a third party  
2 to provide necessary documentation. In such instances where additional  
3 time is necessary because of a lack of necessary documentation, an  
4 insurer shall make every effort to obtain such information as soon as  
5 possible and shall make a final determination within twenty-one days of  
6 receiving the necessary documentation.

7 (b) For the purposes of this section, "facility" shall mean a health  
8 care provider that is licensed or certified pursuant to article five,  
9 twenty-eight, thirty-six, forty, forty-four, or forty-seven of the  
10 public health law or article sixteen, nineteen, thirty-one, thirty-two,  
11 or thirty-six of the mental hygiene law.

12 § 4. The public health law is amended by adding a new section 4406-h  
13 to read as follows:

14 § 4406-h. Health care facility applications. 1. A health care plan  
15 shall, upon request, make available and disclose to facilities written  
16 application procedures and minimum qualification requirements that a  
17 facility must meet in order to be considered by the health care plan for  
18 participation in the in-network benefits portion of the health care  
19 plan's network. The health care plan shall consult with appropriately  
20 qualified facilities in developing its qualification requirements. A  
21 health care plan shall complete review of the facility's application to  
22 participate in the in-network portion of the health care plan's network  
23 and shall, within sixty days of receiving a facility's completed appli-  
24 cation to participate in the health care plan's network, notify the  
25 facility as to: (a) whether the facility is credentialed; or (b) wheth-  
26 er additional time is necessary to make a determination because of a  
27 failure of a third party to provide necessary documentation. In such  
28 instances where additional time is necessary because of a lack of neces-



1 sary documentation, a health care plan shall make every effort to obtain  
2 such information as soon as possible and shall make a final determi-  
3 nation within twenty-one days of receiving the necessary documentation.

4 2. For the purposes of this section, "facility" shall mean a health  
5 care provider entity or organization that is licensed or certified  
6 pursuant to article five, twenty-eight, thirty-six, forty, forty-four,  
7 or forty-seven of this chapter or article sixteen, nineteen, thirty-one,  
8 thirty-two, or thirty-six of the mental hygiene law.

9 § 5. Subsection (g) of section 4905 of the insurance law, as added by  
10 chapter 705 of the laws of 1996, is amended to read as follows:

11 (g) When making prospective, concurrent and retrospective determi-  
12 nations, utilization review agents shall collect only such information  
13 as is necessary to make such determination and shall not routinely  
14 require health care providers to numerically code diagnoses or proce-  
15 dures to be considered for certification or routinely request copies of  
16 medical records of all patients reviewed. During prospective or concur-  
17 rent review, copies of medical records shall only be required when  
18 necessary to verify that the health care services subject to such review  
19 are medically necessary. In such cases, only the necessary or relevant  
20 sections of the medical record shall be required. A utilization review  
21 agent may request copies of partial or complete medical records retros-  
22 pectively. [This subsection shall not apply to health maintenance organ-  
23 izations licensed pursuant to article forty-three of this chapter or  
24 certified pursuant to article forty-four of the public health law.]

25 § 6. Subdivision 7 of section 4905 of the public health law, as added  
26 by chapter 705 of the laws of 1996, is amended to read as follows:

27 7. When making prospective, concurrent and retrospective determi-  
28 nations, utilization review agents shall collect only such information

1 as is necessary to make such determination and shall not routinely  
2 require health care providers to numerically code diagnoses or proce-  
3 dures to be considered for certification or routinely request copies of  
4 medical records of all patients reviewed. During prospective or concur-  
5 rent review, copies of medical records shall only be required when  
6 necessary to verify that the health care services subject to such review  
7 are medically necessary. In such cases, only the necessary or relevant  
8 sections of the medical record shall be required. A utilization review  
9 agent may request copies of partial or complete medical records retros-  
10 pectively. [This subdivision shall not apply to health maintenance  
11 organizations licensed pursuant to article forty-three of the insurance  
12 law or certified pursuant to article forty-four of this chapter.]

13 § 7. This act shall take effect immediately; provided, however, that  
14 sections one through four of this act shall apply to credentialing  
15 applications received on or after the ninetieth day after this act shall  
16 have become a law; and provided further, that sections five and six of  
17 this act shall apply to health care services performed on or after the  
18 ninetieth day after this act shall have become a law.

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

1 § 3. This act shall take effect immediately, provided, however, that  
2 the applicable effective dates of Subparts A through C of this act shall  
3 be as specifically set forth in the last section of such Subparts.

4 PART BB

5 Section 1. Paragraph (b) of subdivision 3 of section 273 of the public  
6 health law, as added by section 10 of part C of chapter 58 of the laws  
7 of 2005, is amended to read as follows:

8 (b) In the event that the patient does not meet the criteria in para-  
9 graph (a) of this subdivision, the prescriber may provide additional  
10 information to the program to justify the use of a prescription drug  
11 that is not on the preferred drug list. The program shall provide a  
12 reasonable opportunity for a prescriber to reasonably present his or her  
13 justification of prior authorization. [If, after consultation with the  
14 program, the prescriber, in his or her reasonable professional judgment,  
15 determines that] The program will consider the additional information  
16 and the justification presented to determine whether the use of a  
17 prescription drug that is not on the preferred drug list is warranted,  
18 and the [prescriber's] program's determination shall be final.

19 § 2. Subdivisions 25 and 25-a of section 364-j of the social services  
20 law are REPEALED.

21 § 3. This act shall take effect June 1, 2022.

22 PART CC

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

4 (m) Beginning April first, two thousand [twenty-three] twenty-five,  
5 additional assisted living program beds shall be approved on a case by  
6 case basis whenever the commissioner of health is satisfied that public  
7 need exists at the time and place and under circumstances proposed by  
8 the applicant.

9 (i) The consideration of public need may take into account factors  
10 such as, but not limited to, regional occupancy rates for adult care  
11 facilities and assisted living program occupancy rates and the extent to  
12 which the project will serve individuals receiving medical assistance.

13 (ii) Existing assisted living program providers may apply for approval  
14 to add up to nine additional assisted living program beds that do not  
15 require major renovation or construction under an expedited review proc-  
16 ess. The expedited review process is available to applicants that are in  
17 good standing with the department of health, and are in compliance with  
18 appropriate state and local requirements as determined by the department  
19 of health. The expedited review process shall allow certification of the  
20 additional beds for which the commissioner of health is satisfied that  
21 public need exists within ninety days of such department's receipt of a  
22 satisfactory application.

23 § 2. Subdivision (f) of section 129 of part C of chapter 58 of the  
24 laws of 2009, amending the public health law relating to payment by  
25 governmental agencies for general hospital inpatient services, as  
26 amended by section 6 of part E of chapter 57 of the laws of 2019, is  
27 amended to read as follows:

1 (f) section twenty-five of this act shall expire and be deemed  
2 repealed April 1, [2022] 2025;

3 § 3. Subdivision (c) of section 122 of part E of chapter 56 of the  
4 laws of 2013 amending the public health law relating to the general  
5 public health work program, as amended by section 7 of part E of chapter  
6 57 of the laws of 2019, is amended to read as follows:

7 (c) section fifty of this act shall take effect immediately [and shall  
8 expire nine years after it becomes law];

9 § 4. Paragraph (a) of subdivision 1 of section 212 of chapter 474 of  
10 the laws of 1996, amending the education law and other laws relating to  
11 rates for residential healthcare facilities, as amended by section 22 of  
12 part E of chapter 57 of the laws of 2019, is amended to read as follows:

13 (a) Notwithstanding any inconsistent provision of law or regulation to  
14 the contrary, effective beginning August 1, 1996, for the period April  
15 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1,  
16 1998 through March 31, 1999, August 1, 1999, for the period April 1,  
17 1999 through March 31, 2000, April 1, 2000, for the period April 1, 2000  
18 through March 31, 2001, April 1, 2001, for the period April 1, 2001  
19 through March 31, 2002, April 1, 2002, for the period April 1, 2002  
20 through March 31, 2003, and for the state fiscal year beginning April 1,  
21 2005 through March 31, 2006, and for the state fiscal year beginning  
22 April 1, 2006 through March 31, 2007, and for the state fiscal year  
23 beginning April 1, 2007 through March 31, 2008, and for the state fiscal  
24 year beginning April 1, 2008 through March 31, 2009, and for the state  
25 fiscal year beginning April 1, 2009 through March 31, 2010, and for the  
26 state fiscal year beginning April 1, 2010 through March 31, 2016, and  
27 for the state fiscal year beginning April 1, 2016 through March 31,  
28 2019, and for the state fiscal year beginning April 1, 2019 through

1 March 31, 2022, and for the state fiscal year beginning April 1, 2022  
2 through March 31, 2025, the department of health is authorized to pay  
3 public general hospitals, as defined in subdivision 10 of section 2801  
4 of the public health law, operated by the state of New York or by the  
5 state university of New York or by a county, which shall not include a  
6 city with a population of over one million, of the state of New York,  
7 and those public general hospitals located in the county of Westchester,  
8 the county of Erie or the county of Nassau, additional payments for  
9 inpatient hospital services as medical assistance payments pursuant to  
10 title 11 of article 5 of the social services law for patients eligible  
11 for federal financial participation under title XIX of the federal  
12 social security act in medical assistance pursuant to the federal laws  
13 and regulations governing disproportionate share payments to hospitals  
14 up to one hundred percent of each such public general hospital's medical  
15 assistance and uninsured patient losses after all other medical assist-  
16 ance, including disproportionate share payments to such public general  
17 hospital for 1996, 1997, 1998, and 1999, based initially for 1996 on  
18 reported 1994 reconciled data as further reconciled to actual reported  
19 1996 reconciled data, and for 1997 based initially on reported 1995  
20 reconciled data as further reconciled to actual reported 1997 reconciled  
21 data, for 1998 based initially on reported 1995 reconciled data as  
22 further reconciled to actual reported 1998 reconciled data, for 1999  
23 based initially on reported 1995 reconciled data as further reconciled  
24 to actual reported 1999 reconciled data, for 2000 based initially on  
25 reported 1995 reconciled data as further reconciled to actual reported  
26 2000 data, for 2001 based initially on reported 1995 reconciled data as  
27 further reconciled to actual reported 2001 data, for 2002 based initial-  
28 ly on reported 2000 reconciled data as further reconciled to actual

1 reported 2002 data, and for state fiscal years beginning on April 1,  
2 2005, based initially on reported 2000 reconciled data as further recon-  
3 ciled to actual reported data for 2005, and for state fiscal years  
4 beginning on April 1, 2006, based initially on reported 2000 reconciled  
5 data as further reconciled to actual reported data for 2006, for state  
6 fiscal years beginning on and after April 1, 2007 through March 31,  
7 2009, based initially on reported 2000 reconciled data as further recon-  
8 ciled to actual reported data for 2007 and 2008, respectively, for state  
9 fiscal years beginning on and after April 1, 2009, based initially on  
10 reported 2007 reconciled data, adjusted for authorized Medicaid rate  
11 changes applicable to the state fiscal year, and as further reconciled  
12 to actual reported data for 2009, for state fiscal years beginning on  
13 and after April 1, 2010, based initially on reported reconciled data  
14 from the base year two years prior to the payment year, adjusted for  
15 authorized Medicaid rate changes applicable to the state fiscal year,  
16 and further reconciled to actual reported data from such payment year,  
17 and to actual reported data for each respective succeeding year. The  
18 payments may be added to rates of payment or made as aggregate payments  
19 to an eligible public general hospital.

20 § 5. Section 5 of chapter 21 of the laws of 2011, amending the educa-  
21 tion law relating to authorizing pharmacists to perform collaborative  
22 drug therapy management with physicians in certain settings, as amended  
23 by section 20 of part BB of chapter 56 of the laws of 2020, is amended  
24 to read as follows:

25 § 5. This act shall take effect on the one hundred twentieth day after  
26 it shall have become a law[, provided, however, that the provisions of  
27 sections two, three, and four of this act shall expire and be deemed  
28 repealed July 1, 2022; provided, however, that the amendments to subdi-

1 vision 1 of section 6801 of the education law made by section one of  
2 this act shall be subject to the expiration and reversion of such subdi-  
3 vision pursuant to section 8 of chapter 563 of the laws of 2008, when  
4 upon such date the provisions of section one-a of this act shall take  
5 effect; provided, further, that effective]. Effective immediately, the  
6 addition, amendment and/or repeal of any rule or regulation necessary  
7 for the implementation of this act on its effective date are authorized  
8 and directed to be made and completed on or before such effective date.

9 § 6. Section 2 of part II of chapter 54 of the laws of 2016, amending  
10 part C of chapter 58 of the laws of 2005 relating to authorizing  
11 reimbursements for expenditures made by or on behalf of social services  
12 districts for medical assistance for needy persons and administration  
13 thereof, as amended by section 1 of item C of subpart H of part XXX of  
14 chapter 58 of the laws of 2020, is amended to read as follows:

15 § 2. This act shall take effect immediately and shall expire and be  
16 deemed repealed March 31, [2022] 2024.

17 § 7. Section 5 of part ZZ of chapter 56 of the laws of 2020 amending  
18 the tax law and the social services law relating to certain Medicaid  
19 management, is amended to read as follows:

20 § 5. This act shall take effect immediately [and shall be deemed  
21 repealed two years after such effective date].

22 § 8. Paragraph (c) of subdivision 6 of section 958 of the executive  
23 law, as added by chapter 337 of the laws of 2018, is amended to read as  
24 follows:

25 (c) prepare and issue a report on the working group's findings and  
26 recommendations by May first, two thousand [nineteen] twenty-three to  
27 the governor, the temporary president of the senate and the speaker of  
28 the assembly.



1 § 9. Subdivision 2 of section 207-a of the public health law, as added  
2 by chapter 364 of the laws of 2018, is amended to read as follows:

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

10 § 10. Sections 2 and 3 of chapter 74 of the laws of 2020 relating to  
11 directing the department of health to convene a work group on rare  
12 diseases, as amended by chapter 199 of the laws of 2021, are amended to  
13 read as follows:

14 § 2. The department of health, in collaboration with the department of  
15 financial services, shall convene a workgroup of individuals with exper-  
16 tise in rare diseases, including physicians, nurses and other health  
17 care professionals with experience researching, diagnosing or treating  
18 rare diseases; members of the scientific community engaged in rare  
19 disease research; representatives from the health insurance industry;  
20 individuals who have a rare disease or caregivers of a person with a  
21 rare disease; and representatives of rare disease patient organizations.  
22 The workgroup's focus shall include, but not be limited to: identifying  
23 best practices that could improve the awareness of rare diseases and  
24 referral of people with potential rare diseases to specialists and eval-  
25 uating barriers to treatment, including financial barriers on access to  
26 care. The department of health shall prepare a written report summariz-  
27 ing opinions and recommendations from the workgroup which includes a  
28 list of existing, publicly accessible resources on research, diagnosis,

1 treatment, coverage options and education relating to rare diseases. The  
2 workgroup shall convene no later than December twentieth, two thousand  
3 twenty-one and this report shall be submitted to the governor, speaker  
4 of the assembly and temporary president of the senate no later than  
5 [three] four years following the effective date of this act and shall be  
6 posted on the department of health's website.

7 § 3. This act shall take effect on the same date and in the same  
8 manner as a chapter of the laws of 2019, amending the public health law  
9 relating to establishing the rare disease advisory council, as proposed  
10 in legislative bills numbers S. 4497 and A. 5762; provided, however,  
11 that the provisions of section two of this act shall expire and be  
12 deemed repealed [three] four years after such effective date.

13 § 11. Sections 5 and 6 of chapter 414 of the laws of 2018, creating  
14 the radon task force, as amended by section 1 of item M of subpart B of  
15 part XXX of chapter 58 of the laws of 2020, are amended to read as  
16 follows:

17 § 5. A report of the findings and recommendations of the task force  
18 and any proposed legislation necessary to implement such findings shall  
19 be filed with the governor, the temporary president of the senate, the  
20 speaker of the assembly, the minority leader of the senate, and the  
21 minority leader of the assembly on or before November first, two thou-  
22 sand [twenty-one] twenty-two.

23 § 6. This act shall take effect immediately and shall expire and be  
24 deemed repealed December 31, [2021] 2022.

25 § 12. This act shall take effect immediately and shall be deemed to  
26 have been in full force and effect on and after April 1, 2022; provided,  
27 however, that the amendments to section 2 of chapter 74 of the laws of  
28 2020 made by section ten of this section and the amendments to section 5

1 of chapter 414 of the laws of 2018 made by section eleven of this act,  
2 shall not affect the expiration of such section and be deemed to expire  
3 therewith.

4 PART DD

5 Section 1. 1. Subject to available appropriations and approval of the  
6 director of the budget, the commissioners of the office of mental  
7 health, office for people with developmental disabilities, office of  
8 addiction services and supports, office of temporary and disability  
9 assistance, office of children and family services, and the state office  
10 for the aging shall establish a state fiscal year 2022-23 cost of living  
11 adjustment (COLA), effective April 1, 2022, for projecting for the  
12 effects of inflation upon rates of payments, contracts, or any other  
13 form of reimbursement for the programs and services listed in paragraphs  
14 (i), (ii), (iii), (iv), (v), and (vi) of subdivision four of this  
15 section. The COLA established herein shall be applied to the appropri-  
16 ate portion of reimbursable costs or contract amounts. Where appropri-  
17 ate, transfers to the department of health (DOH) shall be made as  
18 reimbursement for the state share of medical assistance.

19 2. Notwithstanding any inconsistent provision of law, subject to the  
20 approval of the director of the budget and available appropriations  
21 therefore, for the period of April 1, 2022 through March 31, 2023, the  
22 commissioners shall provide funding to support a five and four-tenths  
23 percent (5.4%) cost of living adjustment under this section for all  
24 eligible programs and services as determined pursuant to subdivision  
25 four of this section.

1 3. Notwithstanding any inconsistent provision of law, and as approved  
2 by the director of the budget, the 5.4 percent cost of living adjustment  
3 (COLA) established herein shall be inclusive of all other cost of living  
4 type increases, inflation factors, or trend factors that are newly  
5 applied effective April 1, 2022. Except for the 5.4 percent cost of  
6 living adjustment (COLA) established herein, for the period commencing  
7 on April 1, 2022 and ending March 31, 2023 the commissioners shall not  
8 apply any other new cost of living adjustments for the purpose of estab-  
9 lishing rates of payments, contracts or any other form of reimbursement.  
10 The phrase "all other cost of living type increases, inflation factors,  
11 or trend factors" as defined in this subdivision shall not include  
12 payments made pursuant to the American Rescue Plan Act or other federal  
13 relief programs related to the Coronavirus Disease 2019 (COVID-19)  
14 pandemic Public Health Emergency.

15 4. Eligible programs and services. (i) Programs and services funded,  
16 licensed, or certified by the office of mental health (OMH) eligible for  
17 the cost of living adjustment established herein, pending federal  
18 approval where applicable, include: office of mental health licensed  
19 outpatient programs, pursuant to parts 587 and 599 of title 14 CRR-NY of  
20 the office of mental health regulations including clinic, continuing day  
21 treatment, day treatment, intensive outpatient programs and partial  
22 hospitalization; outreach; crisis residence; crisis stabilization,  
23 crisis/respite beds; mobile crisis, part 590 comprehensive psychiatric  
24 emergency program services; crisis intervention; home based crisis  
25 intervention; family care; supported single room occupancy; supported  
26 housing; supported housing community services; treatment congregate;  
27 supported congregate; community residence - children and youth;  
28 treatment/apartment; supported apartment; community residence single

1 room occupancy; on-site rehabilitation; employment programs; recreation;  
2 respite care; transportation; psychosocial club; assertive community  
3 treatment; case management; care coordination, including health home  
4 plus services; local government unit administration; monitoring and  
5 evaluation; children and youth vocational services; single point of  
6 access; school-based mental health program; family support children and  
7 youth; advocacy/support services; drop in centers; recovery centers;  
8 transition management services; bridger; home and community based waiver  
9 services; behavioral health waiver services authorized pursuant to the  
10 section 1115 MRT waiver; self-help programs; consumer service dollars;  
11 conference of local mental hygiene directors; multicultural initiative;  
12 ongoing integrated supported employment services; supported education;  
13 mentally ill/chemical abuse (MICA) network; personalized recovery  
14 oriented services; children and family treatment and support services;  
15 residential treatment facilities operating pursuant to part 584 of title  
16 14-NYCRR; geriatric demonstration programs; community-based mental  
17 health family treatment and support; coordinated children's service  
18 initiative; homeless services; and promises zone.

19 (ii) Programs and services funded, licensed, or certified by the  
20 office for people with developmental disabilities (OPWDD) eligible for  
21 the cost of living adjustment established herein, pending federal  
22 approval where applicable, include: local/unified services; chapter 620  
23 services; voluntary operated community residential services; article 16  
24 clinics; day treatment services; family support services; 100% day  
25 training; epilepsy services; traumatic brain injury services; hepatitis  
26 B services; independent practitioner services for individuals with  
27 intellectual and/or developmental disabilities; crisis services for  
28 individuals with intellectual and/or developmental disabilities; family

1 care residential habilitation; supervised residential habilitation;  
2 supportive residential habilitation; respite; day habilitation; prevoca-  
3 tional services; supported employment; community habilitation; interme-  
4 diate care facility day and residential services; specialty hospital;  
5 pathways to employment; intensive behavioral services; basic home and  
6 community based services (HCBS) plan support; health home services  
7 provided by care coordination organizations; community transition  
8 services; family education and training; fiscal intermediary; support  
9 broker; and personal resource accounts.

10 (iii) Programs and services funded, licensed, or certified by the  
11 office of addiction services and supports (OASAS) eligible for the cost  
12 of living adjustment established herein, pending federal approval where  
13 applicable, include: medically supervised withdrawal services - residen-  
14 tial; medically supervised withdrawal services - outpatient; medically  
15 managed detoxification; medically monitored withdrawal; inpatient reha-  
16 bilitation services; outpatient opioid treatment; residential opioid  
17 treatment; KEEP units outpatient; residential opioid treatment to absti-  
18 nence; problem gambling treatment; medically supervised outpatient;  
19 outpatient rehabilitation; specialized services substance abuse  
20 programs; home and community based waiver services pursuant to subdivi-  
21 sion 9 of section 366 of the social services law; children and family  
22 treatment and support services; continuum of care rental assistance case  
23 management; NY/NY III post-treatment housing; NY/NY III housing for  
24 persons at risk for homelessness; permanent supported housing; youth  
25 clubhouse; recovery community centers; recovery community organizing  
26 initiative; residential rehabilitation services for youth (RRSY); inten-  
27 sive residential; community residential; supportive living; residential  
28 services; job placement initiative; case management; family support

1 navigator; local government unit administration; peer engagement; voca-  
2 tional rehabilitation; support services; HIV early intervention  
3 services; dual diagnosis coordinator; problem gambling resource centers;  
4 problem gambling prevention; prevention resource centers; primary  
5 prevention services; other prevention services; and community services.

6 (iv) Programs and services funded, licensed, or certified by the  
7 office of temporary and disability assistance (OTDA) eligible for the  
8 cost of living adjustment established herein, pending federal approval  
9 where applicable, include: nutrition outreach and education program  
10 (NOEP).

11 (v) Programs and services funded, licensed, or certified by the office  
12 of children and family services (OCFS) eligible for the cost of living  
13 adjustment established herein, pending federal approval where applica-  
14 ble, include: programs for which the office of children and family  
15 services establishes maximum state aid rates pursuant to section 398-a  
16 of the social services law and section 4003 of the education law; emer-  
17 gency foster homes; foster family boarding homes and therapeutic foster  
18 homes as defined by the regulations of the office of children and family  
19 services; supervised settings as defined by subdivision twenty-two of  
20 section 371 of the social services law; adoptive parents receiving  
21 adoption subsidy pursuant to section 453 of the social services law; and  
22 congregate and scattered supportive housing programs and supportive  
23 services provided under the NY/NY III supportive housing agreement to  
24 young adults leaving or having recently left foster care.

25 (vi) Programs and services funded, licensed, or certified by the state  
26 office for the aging (SOFA) eligible for the cost of living adjustment  
27 established herein, pending federal approval where applicable, include:

1 community services for the elderly; expanded in-home services for the  
2 elderly; and supplemental nutrition assistance program.

3 5. Each local government unit or direct contract provider receiving  
4 funding for the cost of living adjustment established herein shall  
5 submit a written certification, in such form and at such time as each  
6 commissioner shall prescribe, attesting how such funding will be or was  
7 used to first promote the recruitment and retention of non-executive  
8 direct care staff, non-executive direct support professionals, non-exe-  
9 cutive clinical staff, or respond to other critical non-personal service  
10 costs prior to supporting any salary increases or other compensation for  
11 executive level job titles.

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

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

23 PART EE

24 Section 1. Short title. This act shall be known and may be cited as  
25 the "9-8-8 suicide prevention and behavioral health crisis hotline act".



1 § 2. The mental hygiene law is amended by adding a new section 36.03  
2 to read as follows:

3 § 36.03 9-8-8 suicide prevention and behavioral health crisis hotline  
4 system.

5 (a) Definitions. When used in this article, the following words and  
6 phrases shall have the following meanings unless the specific context  
7 clearly indicates otherwise:

8 (1) "9-8-8" means the three digit phone number designated by the  
9 federal communications commission for the purpose of connecting individ-  
10 uals experiencing a behavioral health crisis with suicide prevention and  
11 behavioral health crisis counselors, mobile crisis teams, and crisis  
12 stabilization services and other behavioral health crises services  
13 through the national suicide prevention lifeline.

14 (2) "9-8-8 crisis hotline center" means a state-identified and funded  
15 center participating in the National Suicide Prevention Lifeline Network  
16 to respond to statewide or regional 9-8-8 calls.

17 (3) "Crisis stabilization centers" means facilities providing short-  
18 term observation and crisis stabilization services jointly licensed by  
19 the office of mental health and the office of addiction services and  
20 supports under section 36.01 of this article.

21 (4) "Crisis residential services" means a short-term residential  
22 program designed to provide residential and support services to persons  
23 with symptoms of mental illness who are at risk of or experiencing a  
24 psychiatric crisis.

25 (5) "Crisis intervention services" means the continuum to address  
26 crisis intervention, crisis stabilization, and crisis residential treat-  
27 ment needs that are wellness, resiliency, and recovery oriented. Crisis

1 intervention services include but not limited to: crisis stabilization  
2 centers, mobile crisis teams, and crisis residential services.

3 (6) "Mobile crisis teams" means a team licensed, certified, or author-  
4 ized by the office of mental health and the office of addiction services  
5 and supports to provide community-based mental health or substance use  
6 disorder interventions for individuals who are experiencing a mental  
7 health or substance use disorder crisis.

8 (7) "National suicide prevention lifeline" or "NSPL" means the  
9 national network of local crisis centers that provide free and confiden-  
10 tial emotional support to people in suicidal crisis or emotional  
11 distress twenty-four hours a day, seven days a week via a toll-free  
12 hotline number, which receives calls made through the 9-8-8 system. The  
13 toll-free number is maintained by the Assistant Secretary for Mental  
14 Health and Substance Use under Section 50-E-3 of the Public Health  
15 Service Act, Section 290bb-36c of Title 42 of the United States Code.

16 (b) The commissioner of the office of mental health, in conjunction  
17 with the commissioner of the office of addiction services and supports,  
18 shall have joint oversight of the 9-8-8 suicide prevention and behav-  
19 ioral health crisis hotline and shall work in concert with NSPL for the  
20 purposes of ensuring consistency of public messaging.

21 (c) The commissioner of the office of mental health, in conjunction  
22 with the commissioner of the office of addiction services and supports,  
23 shall, on or before July sixteenth, two thousand twenty-two, designate a  
24 crisis hotline center or centers to provide or arrange for crisis inter-  
25 vention services to individuals accessing the 9-8-8 suicide prevention  
26 and behavioral health crisis hotline from anywhere within the state  
27 twenty-four hours a day, seven days a week. Each 9-8-8 crisis hotline  
28 center shall do all of the following:

1 (1) A designated hotline center shall have an active agreement with  
2 the administrator of the National Suicide Prevention Lifeline for  
3 participation within the network.

4 (2) A designated hotline center shall meet NSPL requirements and best  
5 practices guidelines for operation and clinical standards.

6 (3) A designated hotline center may utilize technology, including but  
7 not limited to, chat and text that is interoperable between and across  
8 the 9-8-8 suicide prevention and behavioral health crisis hotline system  
9 and the administrator of the National Suicide Prevention Lifeline.

10 (4) A designated hotline center shall accept transfers of any call  
11 from 9-1-1 pertaining to a behavioral health crisis.

12 (5) A designated hotline center shall ensure coordination between the  
13 9-8-8 crisis hotline centers, 9-1-1, behavioral health crisis services,  
14 and, when appropriate, other specialty behavioral health warm lines and  
15 hotlines and other emergency services. If a law enforcement, medical,  
16 or fire response is also needed, 9-8-8 and 9-1-1 operators shall coordi-  
17 nate the simultaneous deployment of those services with mobile crisis  
18 services.

19 (6) A designated hotline center shall have the authority to deploy  
20 crisis intervention services, including but not limited to mobile crisis  
21 teams, and coordinate access to crisis stabilization centers, and other  
22 mental health crisis services, as appropriate, and according to guide-  
23 lines and best practices established by New York State and the NSPL.

24 (7) A designated hotline center shall meet the requirements set forth  
25 by New York State and the NSPL for serving high risk and specialized  
26 populations including but not limited to: Black, African American,  
27 Hispanic, Latino, Asian, Pacific Islander, Native American, Alaskan  
28 Native; lesbian, gay, bisexual, transgender, nonbinary, queer, and ques-

1 tioning individuals; individuals with intellectual and developmental  
2 disabilities; individuals experiencing homelessness or housing instabil-  
3 ity; immigrants and refugees; children and youth; older adults; and  
4 religious communities as identified by the federal Substance Abuse and  
5 Mental Health Services Administration, including training requirements  
6 and policies for providing linguistically and culturally competent care.

7 (8) A designated hotline center shall provide follow-up services as  
8 needed to individuals accessing the 9-8-8 suicide prevention and behav-  
9 ioral health crisis hotline consistent with guidance and policies estab-  
10 lished by New York State and the NSPL.

11 (9) A designated hotline center shall provide data, and reports, and  
12 participate in evaluations and quality improvement activities as  
13 required by the office of mental health and the office of addiction  
14 services and supports.

15 (d) The commissioner of the office of mental health, in conjunction  
16 with the commissioner of the office of addiction services and supports,  
17 shall establish a comprehensive list of reporting metrics regarding the  
18 9-8-8 suicide prevention and behavioral health crisis hotline's usage,  
19 services and impact which shall include, at a minimum:

20 (1) The volume of requests for assistance that the 9-8-8 suicide  
21 prevention and behavioral health crisis hotline received;

22 (2) The average length of time taken to respond to each request for  
23 assistance, and the aggregate rates of call abandonment;

24 (3) The types of requests for assistance that the 9-8-8 suicide  
25 prevention and behavioral health crisis hotline received; and

26 (4) The number of mobile crisis teams dispatched.

27 (e) The commissioner of the office of mental health, in conjunction  
28 with the commissioner of the office of addiction services and supports,

1 shall submit an annual report on or by December thirty-first, two thou-  
2 sand twenty-three and annually thereafter, regarding the comprehensive  
3 list of reporting metrics to the governor, the temporary president of  
4 the senate, the speaker of the assembly, the minority leader of the  
5 senate and the minority leader of the assembly.

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

21 § 3. This act shall take effect immediately.

22 PART FF

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

1 5. Pursuant to appropriations within the offices of mental health or  
2 addiction services and supports, the department of health shall reinvest  
3 [funds allocated for behavioral health services, which are general fund  
4 savings directly related to] savings realized through the transition of  
5 populations covered by this section from the applicable Medicaid fee-  
6 for-service system to a managed care model, including savings [resulting  
7 from the reduction of inpatient and outpatient behavioral health  
8 services provided under the Medicaid programs licensed or certified  
9 pursuant to article thirty-one or thirty-two of the mental hygiene law,  
10 or programs that are licensed pursuant to both article thirty-one of the  
11 mental hygiene law and article twenty-eight of the public health law, or  
12 certified under both article thirty-two of the mental hygiene law and  
13 article twenty-eight of the public health law] realized through the  
14 recovery of premiums from managed care providers which represent a  
15 reduction of spending on qualifying behavioral health services against  
16 established premium targets for behavioral health services and the  
17 medical loss ratio applicable to special needs managed care plans, for  
18 the purpose of increasing investment in community based behavioral  
19 health services, including residential services certified by the office  
20 of [alcoholism and substance abuse] addiction services and supports.  
21 The methodologies used to calculate the savings shall be developed by  
22 the commissioner of health and the director of the budget in consulta-  
23 tion with the commissioners of the office of mental health and the  
24 office of [alcoholism and substance abuse] addiction services and  
25 supports. In no event shall the full annual value of the [community  
26 based behavioral health service] reinvestment [savings attributable to  
27 the transition to managed care] pursuant to this subdivision exceed the  
28 [twelve month value of the department of health general fund reductions

1 resulting from such transition] value of the premiums recovered from  
2 managed care providers which represent a reduction of spending on quali-  
3 fyng behavioral health services. Within any fiscal year where appropri-  
4 ation increases are recommended for reinvestment, insofar as managed  
5 care transition savings do not occur as estimated, [and general fund  
6 savings do not result,] then spending for such reinvestment may be  
7 reduced in the next year's annual budget itemization. [The commissioner  
8 of health shall promulgate regulations, and prior to October first, two  
9 thousand fifteen, may promulgate emergency regulations as required to  
10 distribute funds pursuant to this subdivision; provided, however, that  
11 any emergency regulations promulgated pursuant to this section shall  
12 expire no later than December thirty-first, two thousand fifteen.] The  
13 commissioner shall include [detailed descriptions of the methodology  
14 used to calculate savings] information regarding the funds available for  
15 reinvestment[, the results of applying such methodologies, the details  
16 regarding implementation of such reinvestment] pursuant to this  
17 section[, and any regulations promulgated under this subdivision,] in  
18 the annual report required under section forty-five-c of part A of chap-  
19 ter fifty-six of the laws of two thousand thirteen.

20 § 2. This act shall take effect immediately.

21 PART GG

22 Section 1. Section 7 of part H of chapter 57 of the laws of 2019,  
23 amending the public health law relating to waiver of certain regu-  
24 lations, as amended by section 7 of part S of chapter 57 of the laws of  
25 2021, is amended to read as follows:

1 § 7. This act shall take effect immediately and shall be deemed to  
2 have been in full force and effect on and after April 1, 2019, provided,  
3 however, that section two of this act shall expire on April 1, [2022]  
4 2025.

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

7 PART HH

8 Section 1. Section 3309 of the public health law is amended by adding  
9 a new subdivision 8 to read as follows:

10 8. Any pharmacy registered by the New York state department of educa-  
11 tion and the federal Drug Enforcement Administration (DEA) or its  
12 successor agency that maintains a stock of and directly dispenses  
13 controlled substance medications pursuant to prescriptions for humans in  
14 the state of New York, shall maintain a minimum stock of a thirty day  
15 supply of both an opioid antagonist medication and separately an opioid  
16 partial agonist medication for the treatment of an opioid use disorder,  
17 to the extent permitted pursuant to federal wholesaler threshold limits.  
18 For purposes of this subdivision, a thirty day supply of opioid partial  
19 agonist medication shall mean any combination of dosages sufficient to  
20 fill a prescription of sixteen milligrams per day for a period of thirty  
21 days. Where the food and drug administration has defined and approved  
22 one or more therapeutic and pharmaceutical equivalents of these medica-  
23 tions a pharmacy is not required to maintain a stock of all such  
24 versions, so long as at least one version of an opioid antagonist and  
25 one version of an opioid partial agonist medication for the treatment of  
26 an opioid use disorder is available to dispense. Where federal and



1 state laws and regulations permit dispensing of opioid full agonist  
2 medication for the treatment of an opioid use disorder, such pharmacy  
3 may also maintain a stock of opioid full agonist medication consistent  
4 with this subdivision.

5 § 2. This act shall take effect on the one hundred eightieth day after  
6 it shall have become a law.

7 PART II

8 Section 1. Paragraph 38 of section 1.03 of the mental hygiene law, as  
9 amended by chapter 281 of the laws of 2019, is amended to read as  
10 follows:

11 38. "Residential services facility" or "[Alcoholism community] Commu-  
12 nity residence for addiction" means any facility licensed or operated  
13 pursuant to article thirty-two of this chapter which provides residen-  
14 tial services for the treatment of an addiction disorder and a homelike  
15 environment, including room, board and responsible supervision as part  
16 of an overall service delivery system.

17 § 2. Paragraph 1 of subdivision (a) of section 32.05 of the mental  
18 hygiene law, as added by chapter 558 of the laws of 1999, is amended to  
19 read as follows:

20 1. operation of a residential program, including a community residence  
21 for the care, custody, or treatment of persons suffering from [chemical  
22 abuse or dependence] an addictive disorder; provided, however, that  
23 giving domestic care and comfort to a person in the home shall not  
24 constitute such an operation; provided further that the certification of  
25 a recovery residence, developed and administered by the commissioner

1 directly or pursuant to a contract with a designated entity, shall have  
2 the following structure and meaning for purposes of this section:

3 (i)(A) "Recovery residence" means a shared living environment free  
4 from alcohol and illicit drug use which utilizes peer supports and  
5 connection to services to promote sustained recovery from substance use  
6 disorder.

7 (B) "Certified recovery residence" means a recovery residence which  
8 complies with standards for the operation of a certified recovery resi-  
9 dence which are issued by the office.

10 (ii) The commissioner shall regulate and assure the consistent high  
11 quality of certified recovery residences for individuals in recovery  
12 from a substance use disorder. The commissioner, directly or pursuant to  
13 contract with a designated entity, shall implement standards for the  
14 operation of a certified recovery residence, a voluntary certification  
15 process, and conduct ongoing monitoring of recovery residences.

16 (iii) The commissioner shall maintain on the office website a list of  
17 certified recovery residences.

18 § 3. Section 41.52 of the mental hygiene law, as amended by chapter  
19 223 of the laws of 1992, is amended to read as follows:

20 § 41.52 Community residential services for [alcoholism] addiction.

21 (a) The commissioner of [alcoholism and substance abuse services]  
22 addiction services and supports is authorized, within appropriations  
23 made therefor, to establish a continuum of community residential  
24 services for [alcoholism] addictive disorder services.

25 (b) The commissioner shall establish standards for the operation and  
26 funding of community residential services, including but not limited to:

27 (1) criteria for admission to and continued residence in each type of  
28 community residence;

1 (2) periodic evaluation of services provided by community residences;  
2 (3) staffing patterns for each type of community residence; and  
3 (4) guidelines for determining state aid to community residences, as  
4 described in [subdivision (c) of this section] article twenty-five of  
5 this chapter.

6 (c) Within amounts available therefor and subject to regulations  
7 established by the commissioner and notwithstanding any other provisions  
8 of this article, the commissioner may provide state aid to local govern-  
9 ments and to voluntary agencies in an amount up to one hundred percent  
10 of net operating costs of community residences for alcoholism services.  
11 The commissioner shall establish guidelines for determining the amount  
12 of state aid provided pursuant to this section. The guidelines shall be  
13 designed to enable the effective and efficient operation of such resi-  
14 dences and shall include, but need not be limited to, standards for  
15 determining anticipated revenue, for retention and use of income exceed-  
16 ing the anticipated amount and for determining reasonable levels of  
17 uncollectible income. Such state aid to voluntary agencies shall not be  
18 granted unless the proposed community residence is consistent with the  
19 relevant local services plan adopted pursuant to section 41.18 of this  
20 article.

21 § 4. This act shall take effect immediately.

22 PART JJ

23 Section 1. The section heading and subdivisions (a) and (d) of section  
24 19.25 of the mental hygiene law, as added by chapter 223 of the laws of  
25 1992, are amended to read as follows:

26 [Alcohol] Substance use awareness program.

1 (a) The office shall establish [an alcohol] a substance use awareness  
2 program within the office which shall focus upon, but not be limited to,  
3 the health effects and social costs of [alcoholism and alcohol abuse]  
4 alcohol and cannabis use.

5 (d) A certificate of completion shall be sent to the court by the  
6 [office] program upon completion of the program by all participants.

7 § 2. This act shall take effect immediately.

8 PART KK

9 Section 1. Section 9 of section 1 of chapter 359 of the laws of 1968,  
10 constituting the facilities development corporation act is amended by  
11 adding a new subdivision 7 to read as follows:

12 7. Expedited process for mental hygiene facilities dedicated for the  
13 treatment of addiction. To more swiftly combat addiction issues and  
14 consistent with the policies of the state of New York as expressed in  
15 section 19.01 of the mental hygiene law, the provisions of this subdi-  
16 vision shall apply to mental hygiene facilities created, or to be  
17 created, to offer treatment programs, rehabilitation services, and  
18 related and attendant services, for addiction that are licensed, certi-  
19 fied or otherwise authorized by the office of addiction services and  
20 supports.

21 a. Notwithstanding any other provision of law, the corporation shall  
22 have the authority to:

23 (i) acquire by lease, purchase, condemnation, gift or otherwise any  
24 real property it deems necessary or convenient for use as a mental  
25 hygiene facility dedicated to providing addiction programs, rehabili-  
26 tation services, and related and attendant services; and such lease,

1 purchase or acquisition shall be in the name of the state, acting by and  
2 through the corporation or the dormitory authority, and on behalf of the  
3 office of addiction services and supports; and

4 (ii) design, construct, reconstruct, rehabilitate and improve such  
5 mental hygiene facilities on behalf of the office of addiction services  
6 and supports, or cause such facilities to be designed, constructed,  
7 reconstructed, rehabilitated and improved; and

8 (iii) in connection with such design, construction, reconstruction,  
9 rehabilitation and improvement, to install or cause to be installed  
10 water, sewer, gas, electrical, telephone, heating, air conditioning and  
11 other utility services, including appropriate connections; and

12 (iv) make such mental hygiene facility available under lease,  
13 sublease, license or permit to a voluntary agency upon such terms and  
14 conditions as determined by the office of addiction services and  
15 supports; or, notwithstanding the provisions of the public lands law or  
16 any other general or special law to the contrary, to convey the right,  
17 title and interest of the people of the state of New York in and to such  
18 facility and the land appurtenant thereto to such voluntary agency to  
19 operate as a mental hygiene facility upon such terms and conditions and  
20 for such consideration, if any, as shall be provided in an agreement  
21 among the office of addiction services and supports, the corporation and  
22 such voluntary agency subject to the attorney general passing upon the  
23 form and sufficiency of any deed of conveyance and any lease of real  
24 property authorized to be given under this subdivision, which shall only  
25 be effective once the deed, lease, sublease or agreement shall have been  
26 so approved. Notwithstanding sections one hundred twelve and one  
27 hundred sixty-three of the state finance law and section one hundred  
28 forty-two of the economic development law, or any other inconsistent

1 provision of law, such voluntary agency may be selected by the office of  
2 addiction services and supports, without a competitive bid or request  
3 for proposal process.

4 b. All contracts which are to be awarded pursuant to this subdivision  
5 shall be publicly advertised pursuant to article four-C of the economic  
6 development law.

7 § 2. This act shall take effect immediately.

8 PART LL

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

13 § 48-a. 1. Notwithstanding any contrary provision of law, the commis-  
14 sioners of the office of [alcoholism and substance abuse] addiction  
15 services and supports and the office of mental health are authorized,  
16 subject to the approval of the director of the budget, to transfer to  
17 the commissioner of health state funds to be utilized as the state share  
18 for the purpose of increasing payments under the medicaid program to  
19 managed care organizations licensed under article 44 of the public  
20 health law or under article 43 of the insurance law. Such managed care  
21 organizations shall utilize such funds for the purpose of reimbursing  
22 providers licensed pursuant to article 28 of the public health law or  
23 article 36, 31 or 32 of the mental hygiene law for ambulatory behavioral  
24 health services, as determined by the commissioner of health, in consul-  
25 tation with the commissioner of [alcoholism and substance abuse]  
26 addiction services and supports and the commissioner of the office of

1 mental health, provided to medicaid enrolled outpatients and for all  
2 other behavioral health services except inpatient included in New York  
3 state's Medicaid redesign waiver approved by the centers for medicare  
4 and Medicaid services (CMS). Such reimbursement shall be in the form of  
5 fees for such services which are equivalent to the payments established  
6 for such services under the ambulatory patient group (APG) rate-setting  
7 methodology as utilized by the department of health, the office of  
8 [alcoholism and substance abuse] addiction services and supports, or the  
9 office of mental health for rate-setting purposes or any such other fees  
10 pursuant to the Medicaid state plan or otherwise approved by CMS in the  
11 Medicaid redesign waiver; provided, however, that the increase to such  
12 fees that shall result from the provisions of this section shall not, in  
13 the aggregate and as determined by the commissioner of health, in  
14 consultation with the commissioner of [alcoholism and substance abuse]  
15 addiction services and supports and the commissioner of the office of  
16 mental health, be greater than the increased funds made available pursu-  
17 ant to this section. The increase of such ambulatory behavioral health  
18 fees to providers available under this section shall be for all rate  
19 periods on and after the effective date of section [1] 18 of part [P] E  
20 of chapter 57 of the laws of [2017] 2019 through March 31, [2023] 2027  
21 for patients in the city of New York, for all rate periods on and after  
22 the effective date of section [1] 18 of part [P] E of chapter 57 of the  
23 laws of [2017] 2019 through March 31, [2023] 2027 for patients outside  
24 the city of New York, and for all rate periods on and after the effec-  
25 tive date of such chapter through March 31, [2023] 2027 for all services  
26 provided to persons under the age of twenty-one; provided, however, the  
27 commissioner of health, in consultation with the commissioner of [alco-  
28 holism and substance abuse] addiction services and supports and the

1 commissioner of mental health, may require, as a condition of approval  
2 of such ambulatory behavioral health fees, that aggregate managed care  
3 expenditures to eligible providers meet the alternative payment method-  
4 ology requirements as set forth in attachment I of the New York state  
5 medicaid section one thousand one hundred fifteen medicaid redesign team  
6 waiver as approved by the centers for medicare and medicaid services.  
7 The commissioner of health shall, in consultation with the commissioner  
8 of [alcoholism and substance abuse] addiction services and supports and  
9 the commissioner of mental health, waive such conditions if a sufficient  
10 number of providers, as determined by the commissioner, suffer a finan-  
11 cial hardship as a consequence of such alternative payment methodology  
12 requirements, or if he or she shall determine that such alternative  
13 payment methodologies significantly threaten individuals access to ambu-  
14 latory behavioral health services. Such waiver may be applied on a  
15 provider specific or industry wide basis. Further, such conditions may  
16 be waived, as the commissioner determines necessary, to comply with  
17 federal rules or regulations governing these payment methodologies.  
18 Nothing in this section shall prohibit managed care organizations and  
19 providers from negotiating different rates and methods of payment during  
20 such periods described above, subject to the approval of the department  
21 of health. The department of health shall consult with the office of  
22 [alcoholism and substance abuse] addiction services and supports and the  
23 office of mental health in determining whether such alternative rates  
24 shall be approved. The commissioner of health may, in consultation with  
25 the commissioner of [alcoholism and substance abuse] addiction services  
26 and supports and the commissioner of the office of mental health,  
27 promulgate regulations, including emergency regulations promulgated  
28 prior to October 1, 2015 to establish rates for ambulatory behavioral



1 health services, as are necessary to implement the provisions of this  
2 section. Rates promulgated under this section shall be included in the  
3 report required under section 45-c of part A of this chapter.

4 2. Notwithstanding any contrary provision of law, the fees paid by  
5 managed care organizations licensed under article 44 of the public  
6 health law or under article 43 of the insurance law, to providers  
7 licensed pursuant to article 28 of the public health law or article 36,  
8 31 or 32 of the mental hygiene law, for ambulatory behavioral health  
9 services provided to patients enrolled in the child health insurance  
10 program pursuant to title 1-A of article 25 of the public health law,  
11 shall be in the form of fees for such services which are equivalent to  
12 the payments established for such services under the ambulatory patient  
13 group (APG) rate-setting methodology or any such other fees established  
14 pursuant to the Medicaid state plan. The commissioner of health shall  
15 consult with the commissioner of [alcoholism and substance abuse]  
16 addiction services and supports and the commissioner of the office of  
17 mental health in determining such services and establishing such fees.  
18 Such ambulatory behavioral health fees to providers available under this  
19 section shall be for all rate periods on and after the effective date of  
20 this chapter through March 31, [2023] 2027, provided, however, that  
21 managed care organizations and providers may negotiate different rates  
22 and methods of payment during such periods described above, subject to  
23 the approval of the department of health. The department of health  
24 shall consult with the office of [alcoholism and substance abuse]  
25 addiction services and supports and the office of mental health in  
26 determining whether such alternative rates shall be approved. The  
27 report required under section 16-a of part C of chapter 60 of the laws  
28 of 2014 shall also include the population of patients enrolled in the

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

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

9 Section 1. a. Notwithstanding any contrary provision of law, the  
10 commissioners of mental health and [alcoholism and substance abuse]  
11 addiction services and supports are authorized, subject to the approval  
12 of the director of the budget, to transfer to the commissioner of health  
13 state funds to be utilized as the state share for the purpose of  
14 increasing payments under the Medicaid program to managed care organiza-  
15 tions licensed under article 44 of the public health law or under arti-  
16 cle 43 of the insurance law. Such managed care organizations shall  
17 utilize such funds for the purpose of reimbursing providers licensed  
18 pursuant to article 28 of the public health law, or pursuant to article  
19 36, 31 or article 32 of the mental hygiene law for ambulatory behavioral  
20 health services, as determined by the commissioner of health in consul-  
21 tation with the commissioner of mental health and commissioner of [alco-  
22 holism and substance abuse] addiction services and supports, provided to  
23 Medicaid enrolled outpatients and for all other behavioral health  
24 services except inpatient included in New York state's Medicaid redesign  
25 waiver approved by the centers for Medicare and Medicaid services (CMS).  
26 Such reimbursement shall be in the form of fees for such services which  
27 are equivalent to the payments established for such services under the  
28 ambulatory patient group (APG) rate-setting methodology as utilized by

1 the department of health or by the office of mental health or office of  
2 [alcoholism and substance abuse] addiction services and supports for  
3 rate-setting purposes or any such other fees pursuant to the Medicaid  
4 state plan or otherwise approved by CMS in the Medicaid redesign waiver;  
5 provided, however, that the increase to such fees that shall result from  
6 the provisions of this section shall not, in the aggregate and as deter-  
7 mined by the commissioner of health in consultation with the commission-  
8 ers of mental health and [alcoholism and substance abuse] addiction  
9 services and supports, be greater than the increased funds made avail-  
10 able pursuant to this section. The increase of such behavioral health  
11 fees to providers available under this section shall be for all rate  
12 periods on and after the effective date of section [2] 19 of part [P] E  
13 of chapter 57 of the laws of [2017] 2019 through March 31, [2023] 2027  
14 for patients in the city of New York, for all rate periods on and after  
15 the effective date of section [2] 19 of part [P] E of chapter 57 of the  
16 laws of [2017] 2019 through March 31, [2023] 2027 for patients outside  
17 the city of New York, and for all rate periods on and after the effec-  
18 tive date of section [2] 19 of part [P] E of chapter 57 of the laws of  
19 [2017] 2019 through March 31, [2023] 2027 for all services provided to  
20 persons under the age of twenty-one; provided, however, the commissioner  
21 of health, in consultation with the commissioner of [alcoholism and  
22 substance abuse] addiction services and supports and the commissioner of  
23 mental health, may require, as a condition of approval of such ambulato-  
24 ry behavioral health fees, that aggregate managed care expenditures to  
25 eligible providers meet the alternative payment methodology requirements  
26 as set forth in attachment I of the New York state medicaid section one  
27 thousand one hundred fifteen medicaid redesign team waiver as approved  
28 by the centers for medicare and medicaid services. The commissioner of

1 health shall, in consultation with the commissioner of [alcoholism and  
2 substance abuse] addiction services and supports and the commissioner of  
3 mental health, waive such conditions if a sufficient number of provid-  
4 ers, as determined by the commissioner, suffer a financial hardship as a  
5 consequence of such alternative payment methodology requirements, or if  
6 he or she shall determine that such alternative payment methodologies  
7 significantly threaten individuals access to ambulatory behavioral  
8 health services. Such waiver may be applied on a provider specific or  
9 industry wide basis. Further, such conditions may be waived, as the  
10 commissioner determines necessary, to comply with federal rules or regu-  
11 lations governing these payment methodologies. Nothing in this section  
12 shall prohibit managed care organizations and providers from negotiating  
13 different rates and methods of payment during such periods described,  
14 subject to the approval of the department of health. The department of  
15 health shall consult with the office of [alcoholism and substance abuse]  
16 addiction services and supports and the office of mental health in  
17 determining whether such alternative rates shall be approved. The  
18 commissioner of health may, in consultation with the commissioners of  
19 mental health and [alcoholism and substance abuse] addiction services  
20 and supports, promulgate regulations, including emergency regulations  
21 promulgated prior to October 1, 2013 that establish rates for behavioral  
22 health services, as are necessary to implement the provisions of this  
23 section. Rates promulgated under this section shall be included in the  
24 report required under section 45-c of part A of chapter 56 of the laws  
25 of 2013.

26 b. Notwithstanding any contrary provision of law, the fees paid by  
27 managed care organizations licensed under article 44 of the public  
28 health law or under article 43 of the insurance law, to providers

1 licensed pursuant to article 28 of the public health law or article 36,  
2 31 or 32 of the mental hygiene law, for ambulatory behavioral health  
3 services provided to patients enrolled in the child health insurance  
4 program pursuant to title 1-A of article 25 of the public health law,  
5 shall be in the form of fees for such services which are equivalent to  
6 the payments established for such services under the ambulatory patient  
7 group (APG) rate-setting methodology. The commissioner of health shall  
8 consult with the commissioner of [alcoholism and substance abuse]  
9 addiction services and supports and the commissioner of the office of  
10 mental health in determining such services and establishing such fees.  
11 Such ambulatory behavioral health fees to providers available under this  
12 section shall be for all rate periods on and after the effective date of  
13 this chapter through March 31, [2023] 2027, provided, however, that  
14 managed care organizations and providers may negotiate different rates  
15 and methods of payment during such periods described above, subject to  
16 the approval of the department of health. The department of health shall  
17 consult with the office of [alcoholism and substance abuse] addiction  
18 services and supports and the office of mental health in determining  
19 whether such alternative rates shall be approved. The report required  
20 under section 16-a of part C of chapter 60 of the laws of 2014 shall  
21 also include the population of patients enrolled in the child health  
22 insurance program pursuant to title 1-A of article 25 of the public  
23 health law in its examination on the transition of behavioral health  
24 services into managed care.

25 § 3. Section 2 of part H of chapter 111 of the laws of 2010, relating  
26 to increasing Medicaid payments to providers through managed care organ-  
27 izations and providing equivalent fees through an ambulatory patient

1 group methodology, as amended by section 20 of part E of chapter 57 of  
2 the laws of 2019, is amended to read as follows:

3 § 2. This act shall take effect immediately and shall be deemed to  
4 have been in full force and effect on and after April 1, 2010, and shall  
5 expire on March 31, [2023] 2027.

6 § 4. This act shall take effect immediately; provided, however that  
7 the amendments to section 1 of part H of chapter 111 of the laws of  
8 2010, relating to increasing Medicaid payments to providers through  
9 managed care organizations and providing equivalent fees through an  
10 ambulatory patient group methodology, made by section two of this act  
11 shall not affect the expiration of such section and shall expire there-  
12 with.

13 PART MM

14 Section 1. Section 18 of chapter 408 of the laws of 1999, constituting  
15 Kendra's law, as amended by chapter 67 of the laws of 2017, is amended  
16 to read as follows:

17 § 18. This act shall take effect immediately, provided that section  
18 fifteen of this act shall take effect April 1, 2000, provided, further,  
19 that subdivision (e) of section 9.60 of the mental hygiene law as added  
20 by section six of this act shall be effective 90 days after this act  
21 shall become law; and that this act shall expire and be deemed repealed  
22 June 30, [2022] 2027.

23 § 2. Paragraph 4 of subdivision (c) and paragraph 2 of subdivision (h)  
24 of section 9.60 of the mental hygiene law, as amended by chapter 158 of  
25 the laws of 2005, are amended and a new subdivision (s) is added to read  
26 as follows:

1 (4) has a history of lack of compliance with treatment for mental  
2 illness that has:

3 (i) except as otherwise provided in subparagraph (iii) of this para-  
4 graph, prior to the filing of the petition, at least twice within the  
5 last thirty-six months been a significant factor in necessitating hospi-  
6 talization in a hospital, or receipt of services in a forensic or other  
7 mental health unit of a correctional facility or a local correctional  
8 facility, not including any current period, or period ending within the  
9 last six months, during which the person was or is hospitalized or  
10 incarcerated; or

11 (ii) except as otherwise provided in subparagraph (iii) of this para-  
12 graph, prior to the filing of the petition, resulted in one or more acts  
13 of serious violent behavior toward self or others or threats of, or  
14 attempts at, serious physical harm to self or others within the last  
15 forty-eight months, not including any current period, or period ending  
16 within the last six months, in which the person was or is hospitalized  
17 or incarcerated; [and] or

18 (iii) notwithstanding subparagraphs (i) and (ii) of this paragraph,  
19 resulted in the issuance of a court order for assisted outpatient treat-  
20 ment which has expired within the last six months, and since the expira-  
21 tion of the order, the person has experienced a substantial increase in  
22 symptoms of mental illness.

23 (2) The court shall not order assisted outpatient treatment unless an  
24 examining physician, who recommends assisted outpatient treatment and  
25 has personally examined the subject of the petition no more than ten  
26 days before the filing of the petition, testifies in person or by video-  
27 conference at the hearing. Such physician shall state the facts and  
28 clinical determinations which support the allegation that the subject of

1 the petition meets each of the criteria for assisted outpatient treat-  
2 ment.

3 (s) A director of community services or his or her designee may  
4 require a provider of services operated or licensed by the office of  
5 mental health to provide information, including but not limited to clin-  
6 ical records and other information concerning persons receiving assisted  
7 outpatient treatment pursuant to an active assisted outpatient treatment  
8 order, that is deemed necessary by such director or designee to appro-  
9 priately discharge their duties pursuant to section 9.47 of this arti-  
10 cle, and where such provider is required to disclose such information  
11 pursuant to paragraph twelve of subdivision (c) of section 33.13 of this  
12 chapter.

13 § 3. This act shall take effect immediately, provided, however that  
14 the amendments to section 9.60 of the mental hygiene law made by section  
15 two of this act shall not affect the repeal of such section and shall be  
16 deemed repealed therewith.

17 PART NN

18 Section 1. Section 41.38 of the mental hygiene law, as amended by  
19 chapter 218 of the laws of 1988, is amended to read as follows:

20 § 41.38 Rental and mortgage payments of community residential facilities  
21 for the mentally ill.

22 (a) "Supportive housing" shall mean, for the purpose of this section  
23 only, the method by which the commissioner contracts to provide rental  
24 support and funding for non-clinical support services in order to main-  
25 tain recipient stability.





1 § 4. This act shall take effect immediately and shall be deemed to  
2 have been in full force and effect on and after April 1, 2016[;  
3 provided, however, that sections one and two of this act shall expire  
4 and be deemed repealed on March 31, 2022].

5 § 2. This act shall take effect immediately.

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

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