FY 2025 NEW YORK STATE EXECUTIVE BUDGET

HEALTH AND MENTAL HYGIENE
ARTICLE VII LEGISLATION

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Legislative Bill Drafting Commission
12671-01-4

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 2024-2025 state fiscal year)

BUDGBI. HMH Art VII

AN ACT

to amend part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to general hospital reimbursement for annual rates, in relation to known and projected department of health state fund medicaid expenditures (Part A); to amend the public health law, in relation to extending certain provisions related to the issuance of accountable care organ-

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	s34 Fernandez	s28 Krueger	s01 Palumbo	s42 Skoufis
s43 Ashby	s60 Gallivan	s24 Lanza	s21 Parker	s11 Stavisky
s36 Bailey	s12 Gianaris	s16 Liu	s19 Persaud	s45 Stec
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s56 Cooney	s27 Kavanagh	s58 O'Mara	s32 Sepulveda	
s22 Felder	s63 Kennedy	s62 Ortt	s29 Serrano	

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:

a078 Alvarez	a047 Colton	a034 Gonzalez-Rojas	a137 Meeks	a016 Sillitti
a031 Anderson	a140 Conrad		a017 Mikulin	a052 Simon
a121 Angelino	a032 Cook	a150 Goodell	a122 Miller	a075 Simone
a037 Ardila	a039 Cruz	a116 Gray	a051 Mitaynes	a114 Simpson
a035 Aubry	a043 Cunningham	a100 Gunther	a145 Morinello	a094 Slater
a120 Barclay	a021 Curran	a139 Hawley	a144 Norris	a005 Smith
a106 Barrett	a018 Darling	a083 Heastie	a045 Novakhov	a118 Smullen
a105 Beephan	a053 Davila	a028 Hevesi	a069 O'Donnell	a022 Solages
a107 Bendett	a072 De Los Santos	a128 Hunter	a091 Otis	a110 Steck
a082 Benedetto	a003 DeStefano	a029 Hyndman	a132 Palmesano	a010 Stern
a027 Berger	a070 Dickens	a079 Jackson	a088 Paulin	a127 Stirpe
a042 Bichotte Hermelyn	a054 Dilan	a104 Jacobson	a141 Peoples-Stokes	a102 Tague
	a081 Dinowitz	a011 Jean-Pierre		a064 Tannousis
a117 Blankenbush	a147 DiPietro	a134 Jensen	a023 Pheffer Amato	a086 Tapia
a015 Blumencranz	a009 Durso	a115 Jones		a071 Taylor
a073 Bores	a099 Eachus	a125 Kelles	a063 Pirozzolo	a001 Thiele
a098 Brabenec	a048 Eichenstein	a040 Kim	a089 Pretlow	a033 Vanel
a026 Braunstein	a074 Epstein	a013 Lavine	a019 Ra	a055 Walker
a138 Bronson	a109 Fahy	a065 Lee	a030 Raga	a143 Wallace
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a044 Carroll	a068 Gibbs	a130 Manktelow	a090 Sayegh	a077
a058 Chandler-Waterman	a002 Giglio, J.A.	a108 McDonald	a076 Seawright	
	a148 Giglio, J.M.	a014 McDonough	a084 Septimo	
a049 Chang	a066 Glick	a097 McGowan	a092 Shimsky	
a136 Clark		a146 McMahon	a103 Shrestha	

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).

ization certifications and state oversight of antitrust provisions; and to amend part D of chapter 56 of the laws of 2013 amending the social services law relating to eligibility conditions, chapter 649 of the laws of 1996 amending the public health law, the mental hygiene law and the social services law relating to authorizing the establishment of special needs plans, part V of chapter 57 of the laws of 2022 amending the public health law and the insurance law relating to reimbursement for commercial and Medicaid services provided via telehealth, chapter 659 of the laws of 1997 amending the public health law and other laws relating to creation of continuing care retirement communities, part NN of chapter 57 of the laws of 2018 amending the public health law and the state finance law relating to enacting the opioid stewardship act, part II of chapter 54 of the laws of 2016 amending part C of chapter 58 of the laws of 2005 relating to authorizing reimbursements for expenditures made by or on behalf of social services districts for medical assistance for needy persons and administration thereof, part B of chapter 57 of the laws of 2015 amending the social services law and other laws relating to energy audits and/or disaster preparedness reviews of residential healthcare facilities by the commissioner, and part H of chapter 57 of the laws of 2019 amending the public health law relating to waiver of certain regulations, in relation to the effectiveness thereof (Part B); to amend the education law, in relation to removing the exemption for school psychologists to render early intervention services; and to amend chapter 217 of the laws of 2015, amending the education law relating to certified school psychologists and special education services and programs for preschool children with handicapping conditions, in relation to the effectiveness thereof (Part C); to amend the public health law, in relation to reducing the hospital

capital rate add-on; to amend part ZZ of 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 part E of chapter 57 of the laws of 2015, amending the public health law relating to the payment of certain funds for uncompensated care, in relation to certain payments being made as outpatient upper payment limit payments for outpatient hospital services during certain state fiscal years and calendar years; to amend part B of chapter 57 of the laws of 2015, amending the social services law relating to supplemental rebates, in relation to authorizing the department of health to increase operating cost component of rates of payment for general hospital outpatient services and authorizing the department of health to pay a public hospital adjustment to public general hospitals during certain state fiscal years and calendar years; to amend the public health law, in relation to authorizing the commissioner to make additional inpatient hospital payments during certain state fiscal years and calendar years; and to amend part B of chapter 58 of the laws of 2010, amending the social services law and the public health law relating to prescription drug coverage for needy persons and health care initiatives pools, in relation to authorizing the department of health to make Medicaid payment increases for county operated free-standing clinics during certain state fiscal years and calendar years (Part D); to amend the public health law, in relation to freezing the operating component of the rates for skilled nursing facilities, reducing the capital component of the rates for skilled nursing facilities by an additional ten percent, and eligibility for admission to the New York state veterans' home (Part E); to amend the social services law, in relation to making the special needs assisted living residence voucher

program permanent; and to amend the public health law, in relation to assisted living quality improvement standards (Part F); to amend the public health law, in relation to home care worker wage parity; and to repeal certain provisions of the public health law relating thereto (Part G); to amend the financial services law, in relation to excluding managed care plans from the independent resolution process; 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 participating in medicaid managed care programs; to amend part I of chapter 57 of the laws of 2022, providing a one percent across the board payment increase to all qualifying fee-for-service Medicaid rates, in relation to eliminating the one percent rate increase to managed care organizations; and to repeal certain provisions of the social services law relating thereto (Part H); to amend the social services law, in relation to copayments for drugs; to amend the public health law, in relation to prescriber prevails; to amend the public health law, in relation to the Medicaid drug cap and pharmacy cost reporting; and to repeal certain provisions of the social services law relating to coverage for certain prescription drugs (Part I); to amend the social services law, in relation to renaming the basic health program to the essential plan; to amend part H of chapter 57 of the laws of 2021, amending the social services law relating to eliminating consumer-paid premium payments in the basic health program, in relation to the effectiveness thereof; and to amend part BBB of chapter 56 of the laws of 2022, amending the public health law and other laws relating to permitting the commissioner of health to submit a waiver that expands eligibility for New York's basic health program and increases the federal

poverty limit cap for basic health program eligibility from two hundred to two hundred fifty percent, in relation to extending certain provisions related to providing long-term services and supports under the essential plan; and to amend the public health law, in relation to adding references to the 1332 state innovation waiver, providing a new subsidy to assist low-income New Yorkers with the payment of premiums, cost sharing or both through the marketplace, and adding the 1332 state innovation program to the functions of the marketplace (Part J); to amend chapter 266 of the laws of 1986 amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to insurance coverage paid for by funds from the hospital excess liability pool and extending the effectiveness of certain provisions thereof; to amend part J of chapter 63 of the laws of 2001 amending chapter 266 of the laws of 1986 amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to extending certain provisions concerning the hospital excess liability pool; and to amend part H of chapter 57 of the laws of 2017 amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions relating thereto, in relation to extending provisions relating to excess coverage (Part K); to amend the public health law and the state finance law, in relation to the discontinuation of the empire clinical research investigator program; to amend the public health law, in relation to the discontinuance of participation and membership during a three year demonstration period in a physician committee of the Medical Society of the State of New York or the New York State Osteopathic Society; to repeal subdivision 9 of section 2803 of the public health law, relating to the hospital audit program; to

repeal section 461-s of the social services law, relating to enhancing the quality of adult living program for adult care facilities; to repeal paragraph (c) of subdivision 1 of section 461-b of the social services law, relating to an appropriation made available for the purposes of funding the operating assistance sub-program for enriched housing; to repeal article 27-H of the public health law, relating to the tick-borne disease institute; and to repeal paragraph (g) of subdivision 11 of section 230 of the public health law, relating to reporting of professional misconduct (Part L); to amend the social services law and the public health law, in relation to authorizing continuous coverage in Medicaid and child health plus, for eligible children ages zero to six (Part M); to amend the public health law, in relation to authorizing the commissioner of health to issue a statewide standing order for the provision of doula services, providing medical services to pregnant minors, and to the provision of contraception (Part N); to amend the public health law, in relation to expanding financial assistance; and to amend the general business law, in relation to additional consumer protection for medical debt and restricting the applications for and use of credit cards and medical financial products (Part O); to amend part C of chapter 57 of the laws of 2022 amending the public health law and the education law relating to allowing pharmacists to direct limited service laboratories and order and administer COVID-19 and influenza tests and modernizing nurse practitioners, and chapter 21 of the laws of 2011 amending the education law relating to authorizing pharmacists to perform collaborative drug therapy management with physicians in certain settings, in relation to the effectiveness thereof (Part P); to amend the education law and the public health law, in relation to the scope of practice of physician assistants, certified

nurse aides, medical assistants, dentists and dental hygienists (Part Q); to amend the education law, in relation to enacting the interstate medical licensure compact; and to amend the education law, in relation to enacting the nurse licensure compact (Part R); to amend the public health law, in relation to establishing the healthcare safety net transformation program (Part S); to amend the public health law and the education law, in relation to making necessary changes to end the HIV, HCV, HBV, syphilis and mpox epidemics; and to repeal certain provisions the public health law relating thereto (Part T); to amend the public health law, in relation to increasing prescription monitoring program data retention periods and allowing enhanced data sharing to combat the opioid crisis, updating controlled substance schedules to conform with those of the federal drug enforcement administration, permitting providers to distribute three-day supplies of buprenorphine, and updating the term "addict" to "person with a substance use disorder" in certain provisions of such law; and to repeal section 3372 of such law relating to practitioner patient reporting (Part U); to amend the public health law, in relation to expanding hospital services and home care collaboration into the home and community; to amend the public health law and the education law, in relation to modernizing the state of New York's emergency medical system and workforce; to amend the public health law, in relation to establishing the paramedic urgent care program; and to amend chapter 137 of the laws of 2023 amending the public health law relating to establishing a community-based paramedicine demonstration program, in relation to extending the effectiveness thereof (Part V); to amend the elder law, in relation to establishing the interagency elder justice coordinating council (Part W); to amend part NN of chapter 57 of the laws of 2018

amending the public health law and other laws relating to enacting the opioid stewardship act, in relation to making the opioid stewardship fund permanent (Part X); to amend chapter 62 of the laws of 2003, amending the mental hygiene law and the state finance law relating to the community mental health support and workforce reinvestment program, the membership of subcommittees for mental health of community services boards and the duties of such subcommittees and creating the community mental health and workforce reinvestment account, in relation to the effectiveness thereof (Part Y); to amend part NN of chapter 58 of the laws of 2015, amending the mental hygiene law relating to clarifying the authority of the commissioners in the department of mental hygiene to design and implement time-limited demonstration programs, in relation to making such provisions permanent (Part Z); to amend the insurance law, in relation to setting minimal reimbursement for behavioral health treatment (Part AA); to amend chapter 723 of the laws of 1989 amending the mental hygiene law and other laws relating to comprehensive psychiatric emergency programs, in relation to the effectiveness of certain provisions thereof (Part BB); to amend the social services law, in relation to clarifying the requirements related to referrals of substantiated reports of abuse or neglect from the justice center to the office of the Medicaid inspector general (Part CC); to amend part A of chapter 111 of the laws of 2010 amending the mental hygiene law relating to the receipt of federal and state benefits received by individuals receiving care in facilities operated by an office of the department of mental hygiene, in relation to the effectiveness thereof (Part DD); to amend the education law, in relation to expanding the description of certain services which are not prohibited by statutes governing the practice of nursing (Part EE); and

to establish a cost of living adjustment for designated human services programs (Part FF)

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

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

PART A

Section 1. Paragraph (a) of subdivision 1 of section 92 of part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to general hospital reimbursement for annual rates, as amended by section 1 of part A of chapter 57 of the laws of 2023, is amended to read as follows:

(a) For state fiscal years 2011-12 through [2024-25] 2025-26, the director of the budget, in consultation with the commissioner of health referenced as "commissioner" for purposes of this section, shall assess on a quarterly basis, as reflected in quarterly reports pursuant to subdivision five of this section known and projected department of health state funds medicaid expenditures by category of service and by geographic regions, as defined by the commissioner.

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

PART B

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

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

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

§ 10. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after July 1, 1996; provided, however, that sections one, two and three of this act shall expire and be deemed repealed [on] March 31, [2025] 2030 provided, however that the amendments to section 364-j of the social services law made by section four of this act shall not affect the expiration of such section and shall be deemed to expire therewith and provided, further, that the provisions of subdivisions 8, 9 and 10 of section 4401 of the public health law, as added by section one of this act; section 4403-d of the public health law as added by section two of this act and the provisions of section seven of this act, except for the provisions relating to the establishment of no more than twelve comprehensive HIV special needs plans, shall expire and be deemed repealed on July 1, 2000.

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

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

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

1. In order to promote improved quality and efficiency of, and access to, health care services and to promote improved clinical outcomes to the residents of New York, it shall be the policy of the state to encourage, where appropriate, cooperative, collaborative and integrative arrangements including but not limited to, mergers and acquisitions among health care providers or among others who might otherwise be competitors, under the active supervision of the commissioner. To the extent such arrangements, or the planning and negotiations that precede them, might be anti-competitive within the meaning and intent of the state and federal antitrust laws, the intent of the state is to supplant competition with such arrangements under the active supervision and related administrative actions of the commissioner as necessary to accomplish the purposes of this article, and to provide state action immunity under the state and federal antitrust laws with respect to activities undertaken by health care providers and others pursuant to this article, where the benefits of such active supervision, arrange-

ments and actions of the commissioner outweigh any disadvantages likely to result from a reduction of competition. The commissioner shall not approve an arrangement for which state action immunity is sought under this article without first consulting with, and receiving a recommendation from, the public health and health planning council. No arrangement under this article shall be approved after December thirty-first, two thousand [twenty-four] twenty-eight.

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

§ 7. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2022; provided, however, this act shall expire and be deemed repealed on and after April 1, [2024] 2025.

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

§ 97. This act shall take effect immediately, provided, however, that the amendments to subdivision 4 of section 854 of the general municipal law made by section seventy of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith and provided further that sections sixty-seven and sixty-eight of this act shall apply to taxable years beginning on or after January 1, 1998 and provided further that sections eighty-one through eighty-seven of this act shall expire and be deemed repealed on December 31, [2024] 2029 and provided further, however, that the amendments to section ninety of this

act shall take effect January 1, 1998 and shall apply to all policies, contracts, certificates, riders or other evidences of coverage of long term care insurance issued, renewed, altered or modified pursuant to section 3229 of the insurance law on or after such date.

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

§ 5. This act shall take effect July 1, 2018 and shall expire and be deemed to be repealed on June 30, [2024] 2027, provided that, effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date, and, provided that this act shall only apply to the sale or distribution of opioids in the state of New York on or before December 31, 2018.

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

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

§ 9. Subdivision 5 of section 60 of part B of chapter 57 of the laws of 2015 amending the social services law and other laws relating to energy audits and/or disaster preparedness reviews of residential

healthcare facilities by the commissioner, as amended by chapter 125 of the laws of 2021, is amended to read as follows:

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

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

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

§ 11. This act shall take effect immediately.

PART C

Section 1. Paragraph d of subdivision 6 of section 4410 of the education law, as amended by chapter 217 of the laws of 2015, is amended to read as follows:

d. Notwithstanding any other provision of law to the contrary, the exemption in subdivision one of section seventy-six hundred five of this chapter shall apply to persons employed on a full-time or part-time salary basis, which may include on an hourly, weekly, or monthly basis, or on a fee for evaluation services basis provided that such person is employed by and under the dominion and control of a center-based program approved pursuant to subdivision nine of this section as a certified school psychologist to provide activities, services and use of the title psychologist to students enrolled in such approved center-based program;

and to certified school psychologists employed on a full-time or part-time salary basis, which may include on an hourly, weekly, or monthly basis, or on a fee for evaluation services basis provided that the school psychologist is employed by and under the dominion and control of a program that has been approved pursuant to paragraph b of subdivision nine of this section, or subdivision nine-a of this section, to conduct a multi-disciplinary evaluation of a preschool child having or suspected of having a disability where authorized by paragraph a [or b] of subdivision six of section sixty-five hundred three-b of this chapter[; and to certified school psychologists employed on a full-time or part-time salary basis, which may include on an hourly, weekly, or monthly basis, or on a fee for evaluation services basis provided that such psychologist is employed by and under the dominion and control of an agency approved in accordance with title two-A of article twenty-five of the public health law to deliver early intervention program multidisciplinary evaluations, service coordination services and early intervention program services, where authorized by paragraph a or b of subdivision six of section sixty-five hundred three-b of this chapter, each]_ in the course of their employment. Nothing in this section shall be construed to authorize a certified school psychologist or group of such school psychologists to engage in independent practice or practice outside of an employment relationship.

§ 2. Subdivision 1 of section 7605 of the education law, as amended by chapter 217 of the laws of 2015, is amended to read as follows:

1. The activities, services, and use of the title of psychologist, or any derivation thereof, on the part of a person in the employ of a federal, state, county or municipal agency, or other political subdivision, or a chartered elementary or secondary school or degree-granting

educational institution insofar as such activities and services are a part of the duties of his salaried position; or on the part of a person in the employ as a certified school psychologist on a full-time or part-time salary basis, which may include on an hourly, weekly, or monthly basis, or on a fee for evaluation services basis provided that such person employed as a certified school psychologist is employed by and under the dominion and control of a preschool special education program approved pursuant to paragraph b of subdivision nine or subdivision nine-a of section forty-four hundred ten of this chapter to provide activities, services and to use the title "certified school psychologist", so long as this shall not be construed to permit the use of the title "licensed psychologist", to students enrolled in such approved program or to conduct a multidisciplinary evaluation of a preschool child having or suspected of having a disability[; or on the part of a person in the employ as a certified school psychologist on a full-time or part-time salary basis, which may include on an hourly, weekly or monthly basis, or on a fee for evaluation services basis provided that such person employed as a certified school psychologist is employed by and under the dominion and control of an agency approved in accordance with title two-A of article twenty-five of the public health law to deliver early intervention program multidisciplinary evaluations, service coordination services and early intervention program services], where each such preschool special education program [or early intervention provider] is authorized by paragraph a [or b] of subdivision six of section sixty-five hundred [three] <u>three-b</u> of this title[, each] in the course of their employment. Nothing in this subdivision shall be construed to authorize a certified school psychologist or group of such

school psychologists to engage in independent practice or practice outside of an employment relationship.

§ 3. Section 3 of chapter 217 of the laws of 2015, amending the education law relating to certified school psychologists and special education services and programs for preschool children with handicapping conditions, as amended by chapter 339 of the laws of 2022, is amended to read as follows:

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

§ 4. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2024; provided, however, that the amendments to paragraph d of subdivision 6 of section 4410 of the education law made by section one of this act shall not affect the expiration of such paragraph and shall be deemed to expire therewith; provided further, however, that the amendments to subdivision 1 of section 7605 of the education law made by section two of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith.

PART D

Section 1. Paragraph (c) of subdivision 8 of section 2807-c of the public health law, as amended by section 1 of part D of chapter 57 of the laws of 2021, is amended to read as follows:

(c) In order to reconcile capital related inpatient expenses included in rates of payment based on a budget to actual expenses and statistics

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

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

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

paragraph (a) of this subdivision shall be reduced by ten percent relative to the rate in effect on such date.

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

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

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

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

this paragraph shall be made in accordance with paragraph (c) of subdivision eleven of this section. Such adjustments shall not be carried forward except for such volume adjustment as may be authorized in accordance with subparagraph (i) of paragraph (e) of subdivision nine of this section for such general hospital.

§ 2. Section 5 of part ZZ of chapter 56 of the laws of 2020 amending the tax law and the social services law relating to certain Medicaid management, as amended by section 3 of part RR of chapter 57 of the laws of 2022, is amended to read as follows:

§ 5. This act shall take effect immediately and shall be deemed repealed [five] eight years after such effective date.

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

§ 2. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation pursuant to title XIX of the federal social security act, effective for [periods on and after] each state fiscal year from April 1, 2015, through December 31, 2024; and for the calendar year January 1, 2025 through December 31, 2025; and for each calendar year thereafter, payments pursuant to paragraph (i) of subdivision 35 of section 2807-c of the public health law may be made as outpatient upper payment limit payments for outpatient hospital services, not to exceed an amount of three hundred thirty-nine million dollars annually between payments authorized under this section and such section of the public health law. Such payments shall be made as medical assistance payments for outpatient services pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation

under title XIX of the federal social security act for general hospital outpatient services and general hospital emergency room services issued pursuant to paragraph (g) of subdivision 2 of section 2807 of the public health law to general hospitals, other than major public general hospitals, providing emergency room services and including safety net hospitals, which shall, for the purpose of this paragraph, be defined as having either: a Medicaid share of total inpatient hospital discharges of at least thirty-five percent, including both fee-for-service and managed care discharges for acute and exempt services; or a Medicaid share of total discharges of at least thirty percent, including both fee-for-service and managed care discharges for acute and exempt services, and also providing obstetrical services. Eligibility to receive such additional payments shall be based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year. No eligible general hospital's annual payment amount pursuant to this section shall exceed the lower of the sum of the annual amounts due that hospital pursuant to section twenty-eight hundred seven-k and section twenty-eight hundred seven-w of the public health law; or the hospital's facility specific projected disproportionate share hospital payment ceiling established pursuant to federal law, provided, however, that payment amounts to eligible hospitals in excess of the lower of such sum or payment ceiling shall be reallocated to eligible hospitals that do not have excess payment amounts. Such reallocations shall be proportional to each such hospital's aggregate payment amount pursuant to paragraph (i) of subdivision 35 of section 2807-c of the public health law and this section to the total of all payment amounts for such eligible hospitals. Such adjustment payment may be added to rates of

payment or made as aggregate payments to eligible general hospitals other than major public general hospitals. The distribution of such payments shall be pursuant to a methodology approved by the commissioner of health in regulation.

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

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

be paid by means of one or more estimated payments, with such estimated payments to be reconciled to the commissioner of health's final adjustment determinations after the disproportionate share hospital payment adjustment caps have been calculated for such period under sections 1923(f) and (g) of the federal social security act. Such adjustment payment may be added to rates of payment or made as aggregate payments to eligible public general hospitals.

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

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

and then from calendar year January first, two thousand twenty-five through December thirty-first, two thousand twenty-five; and for each calendar year thereafter, to general hospitals, other than major public general hospitals, providing emergency room services and including safety net hospitals, which shall, for the purpose of this paragraph, be defined as having either: a Medicaid share of total inpatient hospital discharges of at least thirty-five percent, including both fee-for-service and managed care discharges for acute and exempt services; or a Medicaid share of total discharges of at least thirty percent, including both fee-for-service and managed care discharges for acute and exempt services, and also providing obstetrical services. Eligibility to receive such additional payments shall be based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year. Such payments shall be made as medical assistance payments for fee-for-service inpatient hospital services pursuant to title eleven of article five of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act and in accordance with the following:

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

§ 18. Notwithstanding any inconsistent provision of law or regulation to the contrary, and subject to the availability of federal financial participation pursuant to title XIX of the federal social security act, effective for [the period] each state fiscal year from April 1, 2012, through [March 31, 2013, and state fiscal years] December 31, 2024; and for the calendar year from January 1, 2025 through December 31, 2025;

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

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

1. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation, effective for [the period] each state fiscal year from August 1, 2010 through [March 31, 2011, and each state fiscal year] December 31, 2024; and for the calendar year from January 1, 2025

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

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

1. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation, effective for [the period] each state fiscal year from August 1, 2010 through [March 31, 2011, and each state fiscal year] December 31, 2024; and for the calendar year from January 1, 2025 through December 31, 2025; and for each calendar year thereafter, the department of health, is authorized to make Medicaid payment increases for county operated diagnostic and treatment centers (DTC) services issued pursuant to section 2807 of the public health law and for

services provided by county operated free-standing clinics licensed pursuant to articles 31 and 32 of the mental hygiene law, but not including facilities operated by the New York City Health and Hospitals Corporation, of up to five million four hundred thousand dollars on an annualized basis for such services pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act. Local social services districts may decline such increased payments to their sponsored DTCs and free-standing clinics, provided they provide written notification to the commissioner of health, within thirty days following receipt of notification of a payment pursuant to this section. Distributions pursuant to this section shall be based on each facility's proportionate share of the sum of all DTC and clinic visits for all facilities receiving payments pursuant to this section for the base year two years prior to the rate year. Such proportionate share payments may be added to rates or payment or made as aggregate payments to eligible facilities.

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

(e-1) Notwithstanding any inconsistent provision of law or regulation, the commissioner shall provide, in addition to payments established pursuant to this article prior to application of this section, additional payments under the medical assistance program pursuant to title eleven of article five of the social services law for non-state operated public residential health care facilities, including public residential health care facilities located in the county of Nassau, the county of Westchester and the county of Erie, but excluding public residential

health care facilities operated by a town or city within a county, in aggregate annual amounts of up to one hundred fifty million dollars in additional payments for the state fiscal year beginning April first, two thousand six and for the state fiscal year beginning April first, two thousand seven and for the state fiscal year beginning April first, two thousand eight and of up to three hundred million dollars in such aggregate annual additional payments for the state fiscal year beginning April first, two thousand nine, and for the state fiscal year beginning April first, two thousand ten and for the state fiscal year beginning April first, two thousand eleven, and for the state fiscal years beginning April first, two thousand twelve and April first, two thousand thirteen, and of up to five hundred million dollars in such aggregate annual additional payments for the state fiscal years beginning April first, two thousand fourteen, April first, two thousand fifteen and April first, two thousand sixteen and of up to five hundred million dollars in such aggregate annual additional payments for the state fiscal years beginning April first, two thousand seventeen, April first, two thousand eighteen, and April first, two thousand nineteen, and of up to five hundred million dollars in such aggregate annual additional payments for the state fiscal years beginning April first, two thousand twenty, April first, two thousand twenty-one, and April first, two thousand twenty-two, and of up to five hundred million dollars in such aggregate annual additional payments for the state fiscal years beginning April first, two thousand twenty-three, and from April first, two thousand twenty-four until December thirty-first, two thousand twenty-four, and [April first, two thousand twenty-five] for the calendar year January first, two thousand twenty-five through December thirty-first, two thousand twenty-five, and for each calendar year thereafter. The

amount allocated to each eligible public residential health care facility for this period shall be computed in accordance with the provisions of paragraph (f) of this subdivision, provided, however, that patient days shall be utilized for such computation reflecting actual reported data for two thousand three and each representative succeeding year as applicable, and provided further, however, that, in consultation with impacted providers, of the funds allocated for distribution in the state fiscal year beginning April first, two thousand thirteen, up to thirty-two million dollars may be allocated in accordance with paragraph (f-1) of this subdivision.

§ 10. This act shall take effect immediately; provided, however, section one of this act shall take effect October 1, 2024; and provided, further, that sections three, four, five, six, seven, eight and nine of this act shall take effect January 1, 2025.

PART E

Section 1. Subparagraph (ii) of paragraph (b) of subdivision 2-b of section 2808 of the public health law, as added by section 47 of part C of chapter 109 of the laws of 2006, is amended to read as follows:

(ii) <u>(A)</u> The operating component of rates shall be subject to case mix adjustment through application of the relative resource utilization groups system of patient classification (RUG-III) employed by the federal government with regard to payments to skilled nursing facilities pursuant to title XVIII of the federal social security act (Medicare), as revised by regulation to reflect New York state wages and fringe benefits, provided, however, that such RUG-III classification system weights shall be increased in the following amounts for the following

categories of residents: [(A)] (1) thirty minutes for the impaired cognition A category, [(B)] (2) forty minutes for the impaired cognition B category, and [(C)] (3) twenty-five minutes for the reduced physical functions B category. Such adjustments shall be made in January and July of each calendar year. Such adjustments and related patient classifications in each facility shall be subject to audit review in accordance with regulations promulgated by the commissioner.

(B) Effective April first, two thousand twenty-four, the operating component of the rates for skilled nursing facilities shall remain unchanged from the January two thousand twenty-four rates during the development and until full implementation of a case mix methodology using the Patient Driven Payment Model.

§ 2. Subparagraph (iv) of paragraph (b) of subdivision 2-b of section 2808 of the public health law, as amended by section 1 of part NN of chapter 56 of the laws of 2020, is amended to read as follows:

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

April first, two thousand twenty-four for rates of payment for patients eligible for payments made by state governmental agencies, the capital cost component determined in accordance with this subparagraph and inclusive of any shared savings for eligible facilities that elect to refinance their mortgage loans pursuant to paragraph (d) of subdivision two-a of this section, shall be reduced by the commissioner by an additional ten percent.

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

(h) in the Persian Gulf conflict from the second day of August, nineteen hundred ninety to the end of such conflict including military service in Operation Enduring Freedom, Operation Iraqi Freedom, Operation New Dawn or Operation Inherent Resolve and was the recipient of the global war on terrorism expeditionary medal or the Iraq campaign medal or the Afghanistan campaign medal; and who was a resident of the state of New York at the time of entry upon such active duty or who shall have been a resident of this state for [one year] six months next preceding the application for admission shall be entitled to admission to said home after the approval of the application by the board of visitors, subject to the provisions of this article and to the conditions, limitations and penalties prescribed by the regulations of the department. Any such veteran or dependent, who otherwise fulfills the requirements set forth in this section, may be admitted directly to the skilled nursing facility or the health related facility provided such veteran or dependent is certified by a physician designated or approved by the department to require the type of care provided by such facilities.

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

PART F

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

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

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

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

(i) report annually on quality measures to be established by the department, in the form and format prescribed by the department, with

the first report due no later than January thirty-first, two thousand twenty-five; and

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

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

(i) Notwithstanding subparagraph one of paragraph (a) of subdivision two of section four hundred sixty-one-a of the social services law, facilities achieving an advanced standing classification shall be surveyed every twelve to eighteen months. All other facilities shall be surveyed on an unannounced basis no less than annually; provided, however, that this shall not apply to surveys, inspections or investigations based on complaints received by the department under any other provision of law.

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

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

§ 3. Subparagraph 1 of paragraph (a) of subdivision 2 of section 461-a of the social services law, as amended by chapter 735 of the laws of 1994, is amended and a new subparagraph 1-a is added to read as follows:

(1) Such facilities receiving the department's highest rating shall be inspected at least once every eighteen months on an unannounced basis. Such rating determination shall be made pursuant to an evaluation of quality indicators as developed by the department and published on the department's website.

(1-a) (i) Adult care facilities dually licensed to provide assisted living pursuant to the requirements specified in section forty-six hundred fifty-three of the public health law may seek accreditation by one or more nationally recognized accrediting agencies determined by the commissioner.

(ii) Such accreditation agencies shall report data and information, in a manner and form as determined by the department, pertaining to those assisted living residences accredited by such agencies, those assisted living residences that seek but do not receive such accreditation, and those assisted living residences which obtain but lose such accreditation.

(iii) Notwithstanding the provisions of subparagraph one of this paragraph, or any other provision of law, assisted living residences which have obtained accreditation from a nationally recognized accreditation organization approved by the department and which meet eligibility criteria, as determined by the department, may, at the discretion of the commissioner, be exempt from the department inspection required in this subdivision for the duration they maintain their accreditation in good standing. The operator of an adult care facility that obtains but subsequently loses accreditation shall report such loss to the department

within ten business days in a manner and form determined by the department and will no longer be exempt from the department inspection required in this subdivision. The department shall post on its website a list of all accredited assisted living residences.

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

PART G

Section 1. Paragraph (i) of subdivision 1 of section 3614-c of the public health law is REPEALED.

§ 2. Paragraph (d) of subdivision 1, and subdivisions 2, 4, 5, 5-a, 6, 6-a, 7, 7-a, 9 and 10 of section 3614-c of the public health law, subdivisions 2, 4, 5, 6, 7, 9 and 10 as amended and subdivisions 6-a and 7-a as added by section 1 and subdivision 5-a as added by section 1-a of part OO of chapter 56 of the laws of 2020, are amended to read as follows:

(d) "Home care aide" means a home health aide, personal care aide, home attendant, [personal assistant performing consumer directed personal assistance services pursuant to section three hundred sixty-five-f of the social services law,] or other licensed or unlicensed person whose primary responsibility includes the provision of in-home assistance with activities of daily living, instrumental activities of daily living or health-related tasks; provided, however, that home care aide does not include any individual (i) working on a casual basis, or

(ii) [(except for a person employed under the consumer directed personal assistance program under section three hundred sixty-five-f of the social services law)] who is a relative through blood, marriage or adoption of: (1) the employer; or (2) the person for whom the worker is delivering services, under a program funded or administered by federal, state or local government.

2. Notwithstanding any inconsistent provision of law, rule or regulation, no payments by government agencies shall be made to certified home health agencies, long term home health care programs, managed care plans, [fiscal intermediaries,] the nursing home transition and diversion waiver program under section three hundred sixty-six of the social services law, or the traumatic brain injury waiver program under section twenty-seven hundred forty of this chapter for any episode of care furnished, in whole or in part, by any home care aide who is compensated at amounts less than the applicable minimum rate of home care aide total compensation established pursuant to this section.

4. The terms of this section shall apply equally to services provided by home care aides who work on episodes of care as direct employees of certified home health agencies, long term home health care programs, or managed care plans, or as employees of licensed home care services agencies, limited licensed home care services agencies, [or fiscal intermediaries,] or under any other arrangement.

5. No payments by government agencies shall be made to certified home health agencies, licensed home care services agencies, long term home health care programs, managed care plans[, fiscal intermediaries] for any episode of care without the certified home health agency, licensed home care services agency, long term home health care program, or managed care plan [or the fiscal intermediary], having delivered prior

written certification to the commissioner annually, at a time prescribed by the commissioner, on forms prepared by the department in consultation with the department of labor, that all services provided under each episode of care during the period covered by the certification are in full compliance with the terms of this section and any regulations promulgated pursuant to this section and that no portion of the dollars spent or to be spent to satisfy the wage or benefit portion under this section shall be returned to the certified home health agency, licensed home care services agency, long term home health care program, or managed care plan, [or fiscal intermediary,] related persons or entities, other than to a home care aide as defined in this section to whom the wage or benefits are due, as a refund, dividend, profit, or in any other manner. Such written certification shall also verify that the certified home health agency, long term home health care program, or managed care plan has received from the licensed home care services agency, [fiscal intermediary,] or other third party an annual statement of wage parity hours and expenses on a form provided by the department of labor accompanied by an independently-audited financial statement verifying such expenses.

5-a. No portion of the dollars spent or to be spent to satisfy the wage or benefit portion under this section shall be returned to the certified home health agency, licensed home care services agency, long term home health care program, or managed care plan, [or fiscal intermediary,] related persons or entities, other than to a home care aide as defined in this section to whom the wage or benefits are due, as a refund, dividend, profit, or in any other manner.

6. If a certified home health agency, long term home health care program or managed care plan elects to provide home care aide services

through contracts with licensed home care services agencies, [fiscal intermediaries,] or through other third parties, provided that the episode of care on which the home care aide works is covered under the terms of this section, the certified home health agency, long term home health care program, or managed care plan shall include in its contracts, a requirement that it be provided with a written certification, verified by oath, from the licensed home care services agency, [fiscal intermediary,] or other third party, on forms prepared by the department in consultation with the department of labor, which attests to the licensed home care services agency's, [fiscal intermediary's,] or other third party's compliance with the terms of this section. Such contracts shall also obligate the licensed home care services agency, [fiscal intermediary,] or other third party to provide the certified home health agency, long term home health care program, or managed care plan all information from the licensed home care services agency, [fiscal intermediary] or other third party necessary to verify compliance with the terms of this section, which shall include an annual compliance statement of wage parity hours and expenses on a form provided by the department of labor accompanied by an independently-audited financial statement verifying such expenses. Such annual statements shall be available no less than annually for the previous calendar year, at a time as prescribed by the commissioner. Such certifications, the information necessary to verify compliance, and the annual compliance statement and financial statements shall be retained by all certified home health agencies, long term home health care programs, or managed care plans, and all licensed home care services agencies, [fiscal intermediaries,] or other third parties for a period of no less than ten years, and made available to the department upon request. Any

licensed home care services agency, [fiscal intermediary,] or other third party who shall upon oath verify any statement required to be transmitted under this section and any regulations promulgated pursuant to this section which is known by such party to be false shall be guilty of perjury and punishable as provided by the penal law.

6-a. The certified home health agency, long term home health care program, or managed care plan shall review and assess the annual compliance statement of wage parity hours and expenses and make a written referral to the department of labor for any reasonably suspected failures of licensed home care services agencies, [fiscal intermediaries,] or third parties to conform to the wage parity requirements of this section.

7. The commissioner shall distribute to all certified home health agencies, long term home health care programs, managed care plans, and licensed home care services agencies[, and fiscal intermediaries] official notice of the minimum rates of home care aide compensation at least one hundred twenty days prior to the effective date of each minimum rate for each social services district covered by the terms of this section.

7-a. Any certified home health agency, licensed home care services agency, long term home health care program, managed care plan, [or fiscal intermediary,] or other third party that willfully pays less than such stipulated minimums regarding wages and supplements, as established in this section, shall be guilty of a misdemeanor and upon conviction shall be punished, for a first offense by a fine of five hundred dollars or by imprisonment for not more than thirty days, or by both fine and imprisonment; for a second offense by a fine of one thousand dollars, and in addition thereto the contract on which the violation has occurred shall be forfeited; and no such person or corporation shall be entitled

to receive any sum nor shall any officer, agent or employee of the state pay the same or authorize its payment from the funds under his or her charge or control to any person or corporation for work done upon any contract, on which the certified home health agency, licensed home care services agency, long term home health care program, managed care plan, [or fiscal intermediary,] or other third party has been convicted of a second offense in violation of the provisions of this section.

9. Nothing in this section should be construed as applicable to any service provided by certified home health agencies, licensed home care services agencies, long term home health care programs[,] or managed care plans[, or fiscal intermediaries] except for all episodes of care reimbursed in whole or in part by the New York Medicaid program.

10. No certified home health agency, managed care plan, or long term home health care program shall be liable for recoupment of payments or any other penalty under this section for services provided through a licensed home care services agency, [fiscal intermediary,] or other third party with which the certified home health agency, long term home health care program, or managed care plan has a contract because the licensed agency, [fiscal intermediary,] or other third party failed to comply with the provisions of this section if the certified home health agency, long term home health care program, or managed care plan has reasonably and in good faith collected certifications and all information required pursuant to this section and conducts the monitoring and reporting required by this section.

§ 3. This act shall take effect October 1, 2024.

PART H

Section 1. Section 602 of the financial services law, as added by section 26 of part H of chapter 60 of the laws of 2014, is amended to read as follows:

§ 602. Applicability. [(a)] This article shall not apply to health care services, including emergency services, where physician fees are subject to schedules or other monetary limitations under any other law, including the workers' compensation law and article fifty-one of the insurance law, and shall not preempt any such law. This article also shall not apply to health care services, including emergency services, subject to medical assistance program coverage provided pursuant to section three hundred sixty-four-j of the social services law.

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

(e) Effective April first, two thousand twenty-four and expiring on the date the commissioner publishes on the department's website a request for proposals in accordance with paragraph (a) of subdivision five of this section, the commissioner shall place a moratorium on the processing and approval of applications seeking authority to establish a managed care provider, including applications seeking authorization to expand the scope of eligible enrollee populations. Such moratorium shall not apply to:

(i) applications submitted to the department prior to January first, two thousand twenty-four;

(ii) applications seeking approval to transfer ownership or control of an existing managed care provider;

(iii) applications seeking authorization to expand an existing managed care provider's approved service area;

(iv) applications seeking authorization to form or operate a managed care provider through an entity certified under section forty-four hundred three-c or forty-four hundred three-g of the public health law;

(v) applications demonstrating to the commissioner's satisfaction that submission of the application for consideration would be appropriate to address a serious concern with care delivery, such as a lack of adequate access to managed care providers in a geographic area or a lack of adequate and appropriate care, language and cultural competence, or special needs services.

§ 3. Subdivision 5 of section 364-j of the social services law, as amended by section 15 of part C of chapter 58 of the laws of 2004, paragraph (a) as amended by section 40 of part A of chapter 56 of the laws of 2013, and paragraphs (d), (e) and (f) as amended by section 80 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

5. Managed care programs shall be conducted in accordance with the requirements of this section and, to the extent practicable, encourage the provision of comprehensive medical services, pursuant to this article.

(a) The [managed care program] commissioner of health shall, through a competitive bid process based on proposals submitted to the department, provide for the selection of qualified managed care providers [by the commissioner of health] to participate in the managed care program pursuant to a contract with the department, including [comprehensive HIV special needs plans and] special needs managed care plans in accordance with the provisions of section three hundred sixty-five-m of this title; provided, however, that the commissioner of health may contract directly with comprehensive HIV special needs plans [consistent with standards set forth in this section] without a competitive bid process, and assure

that such providers are accessible taking into account the needs of persons with disabilities and the differences between rural, suburban, and urban settings, and in sufficient numbers to meet the health care needs of participants, and shall consider the extent to which major public hospitals are included within such providers' networks[.]; and provided further that:

[(b) A proposal] (i) Proposals submitted by a managed care provider to participate in the managed care program shall:

[(i)] (A) designate the geographic [area] areas, as defined by the commissioner in the request for proposals, to be served [by the provider], and estimate the number of eligible participants and actual participants in such designated area;

[(ii)] (B) include a network of health care providers in sufficient numbers and geographically accessible to service program participants;

[(iii)] (C) describe the procedures for marketing in the program location, including the designation of other entities which may perform such functions under contract with the organization;

[(iv)] (D) describe the quality assurance, utilization review and case management mechanisms to be implemented;

[(v)] (E) demonstrate the applicant's ability to meet the data analysis and reporting requirements of the program;

[(vi)] (F) demonstrate financial feasibility of the program; and

[(vii)] (G) include such other information as the commissioner of health may deem appropriate.

[(c) The commissioner of health shall make a determination whether to approve, disapprove or recommend modification of the proposal.

(d) Notwithstanding any inconsistent provision of this title and section one hundred sixty-three of the state finance law, the commis-

sioner of health may contract with managed care providers approved under paragraph (b) of this subdivision, without a competitive bid or request for proposal process, to provide coverage for participants pursuant to this title.

(e) Notwithstanding any inconsistent provision of this title and section one hundred forty-three of the economic development law, no notice in the procurement opportunities newsletter shall be required for contracts awarded by the commissioner of health, to qualified managed care providers pursuant to this section.

(f)] (ii) In addition to the criteria described in subparagraph (i) of this paragraph, the commissioner shall also consider:

(A) accessibility and geographic distribution of network providers, taking into account the needs of persons with disabilities and the differences between rural, suburban, and urban settings;

(B) the extent to which major public hospitals are included in the submitted provider network;

(C) demonstrated cultural and language competencies specific to the population of participants;

(D) the corporate organization and status of the bidder as a charitable corporation under the not-for-profit corporation law;

(E) the ability of a bidder to offer plans in multiple regions;

(F) the type and number of products the bidder proposes to operate, including products bid for in accordance with the provisions of subdivision six of section forty-four hundred three-f of the public health law, and other products determined by the commissioner, including but not necessarily limited to those operated under title one-A of article twenty-five of the public health law and section three hundred sixty-nine-gg of this article;

(G) whether the bidder participates in products for integrated care for participants who are dually eligible for Medicaid and medicare;

(H) whether the bidder participates in value based payment arrangements as defined by the department, including the delegation of significant financial risk to clinically integrated provider networks;

(I) the bidder's commitment to participation in managed care in the state;

(J) the bidder's commitment to quality improvement;

(K) the bidder's commitment to community reinvestment spending, as shall be defined in the procurement;

(L) for current or previously authorized managed care providers, past performance in meeting managed care contract or federal or state requirements, and if the commissioner issued any statements of findings, statements of deficiency, intermediate sanctions or enforcement actions to a bidder for non-compliance with such requirements, whether the bidder addressed such issues in a timely manner; and

(M) any other criteria deemed appropriate by the commissioner.

(iii) Subparagraphs (i) and (ii) of this paragraph describing proposal content and selection criteria requirements shall not be construed as limiting or requiring the commissioner to evaluate such content or criteria on a pass/fail scale, or other methodological basis; provided however, that the commissioner must consider all such content and criteria using methods determined by the commissioner in their discretion and, as applicable, in consultation with the commissioners of the office of mental health, the office for people with developmental disabilities, the office of addiction services and supports, and the office of children and family services.

(iv) The department shall post on its website:

(A) The request for proposals and a description of the proposed services to be provided pursuant to contracts in accordance with this subdivision;

(B) The criteria on which the department shall determine qualified bidders and evaluate their proposals, including all criteria identified in this subdivision;

(C) The manner by which a proposal may be submitted, which may include submission by electronic means;

(D) The manner by which a managed care provider may continue to participate in the managed care program pending award of managed care providers through a competitive bid process pursuant to this subdivision; and

(E) Upon award, the managed care providers that the commissioner intends to contract with pursuant to this subdivision, provided that the commissioner shall update such list to indicate the final slate of contracted managed care providers.

(v) (A) All responsible and responsive submissions that are received from bidders in a timely fashion shall be reviewed by the commissioner of health in consultation with the commissioners of the office of mental health, the office for people with developmental disabilities, the office of addiction services and supports, and the office of children and family services, as applicable. The commissioner shall consider comments resulting from the review of proposals and make awards in consultation with such agencies.

(B) The commissioner may make awards under this subdivision for each product, for which proposals were requested, to two or more managed care providers in each geographic region defined by the commissioner in the request for proposals for which at least two managed care providers have

submitted a proposal, and shall have discretion to offer more contracts based on need for access.

(C) Managed care providers awarded under this subdivision shall be entitled to enter into a contract with the department for the purpose of participating in the managed care program. Such contracts shall run for a term to be determined by the commissioner, which may be renewed or modified from time to time without a new request for proposals, to ensure consistency with changes in federal and state laws, regulations and policies, including but not limited to the expansion or reduction of medical assistance services available to the participants through a managed care provider.

(D) Nothing in this paragraph or other provision of this section shall be construed to limit in any way the ability of the department to terminate awarded contracts for cause, which shall include but not be limited to any violation of the terms of such contracts or violations of state or federal laws and regulations and any loss of necessary state or federal funding.

(E) Nothing in this paragraph or other provision of this section shall be construed to limit in any way the ability of the department to issue a new request for proposals for a term following an existing term of an award.

(b) If necessary to ensure access to a sufficient number of managed care providers on a geographic or other basis, including a lack of adequate and appropriate care, language and cultural competence, or special needs services, the commissioner may reissue a request for proposals as provided for under paragraph (a) of this subdivision, provided however that such request may be limited to the geographic or other basis of need that the request for proposals is seeking to

address. Any awards made shall be subject to the requirements of this section, including but not limited to the minimum and maximum number of awards in a region.

(c) The care and services described in subdivision four of this section will be furnished by a managed care provider pursuant to the provisions of this section when such services are furnished in accordance with an agreement with the department of health, and meet applicable federal law and regulations.

[(g)] (d) The commissioner of health may delegate some or all of the tasks identified in this section to the local districts.

[(h)] (e) Any delegation pursuant to paragraph [(g)] (d) of this subdivision shall be reflected in the contract between a managed care provider and the commissioner of health.

§ 4. Subdivision 4 of section 365-m of the social services law is REPEALED and a new subdivision 4 is added to read as follows:

4. The commissioner of health, jointly with the commissioners of the office of mental health and the office of addiction services and supports, shall select a limited number of special needs managed care plans under section three hundred sixty-four-j of this title, in accordance with subdivision five of such section, capable of managing the behavioral and physical health needs of medical assistance enrollees with significant behavioral health needs.

§ 5. The opening paragraph of subdivision 2 of section 4403-f of the public health law, as amended by section 8 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

An eligible applicant shall submit an application for a certificate of authority to operate a managed long term care plan upon forms prescribed by the commissioner, including any such forms or processes as may be

required or prescribed by the commissioner in accordance with the competitive bid process under subdivision six of this section. Such eligible applicant shall submit information and documentation to the commissioner which shall include, but not be limited to:

§ 6. Subdivision 3 of section 4403-f of the public health law, as amended by section 41-a of part H of chapter 59 of the laws of 2011, is amended to read as follows:

3. Certificate of authority; approval. (a) The commissioner shall not approve an application for a certificate of authority unless the applicant demonstrates to the commissioner's satisfaction:

[(a)] (i) that it will have in place acceptable quality-assurance mechanisms, grievance procedures, mechanisms to protect the rights of enrollees and case management services to ensure continuity, quality, appropriateness and coordination of care;

[(b)] (ii) that it will include an enrollment process which shall ensure that enrollment in the plan is informed. The application shall describe the disenrollment process, which shall provide that an otherwise eligible enrollee shall not be involuntarily disenrolled on the basis of health status;

[(c)] (iii) satisfactory evidence of the character and competence of the proposed operators and reasonable assurance that the applicant will provide high quality services to an enrolled population;

[(d)] (iv) sufficient management systems capacity to meet the requirements of this section and the ability to efficiently process payment for covered services;

[(e)] (v) readiness and capability to maximize reimbursement of and coordinate services reimbursed pursuant to title XVIII of the federal social security act and all other applicable benefits, with such benefit

coordination including, but not limited to, measures to support sound clinical decisions, reduce administrative complexity, coordinate access to services, maximize benefits available pursuant to such title and ensure that necessary care is provided;

[(f)] (vi) readiness and capability to arrange and manage covered services and coordinate non-covered services which could include primary, specialty, and acute care services reimbursed pursuant to title XIX of the federal social security act;

[(g)] (vii) willingness and capability of taking, or cooperating in, all steps necessary to secure and integrate any potential sources of funding for services provided by the managed long term care plan, including, but not limited to, funding available under titles XVI, XVIII, XIX and XX of the federal social security act, the federal older Americans act of nineteen hundred sixty-five, as amended, or any successor provisions subject to approval of the director of the state office for aging, and through financing options such as those authorized pursuant to section three hundred sixty-seven-f of the social services law;

[(h)] (viii) that the contractual arrangements for providers of health and long term care services in the benefit package are sufficient to ensure the availability and accessibility of such services to the proposed enrolled population consistent with guidelines established by the commissioner; with respect to individuals in receipt of such services prior to enrollment, such guidelines shall require the managed long term care plan to contract with agencies currently providing such services, in order to promote continuity of care. In addition, such guidelines shall require managed long term care plans to offer and cover consumer directed personal assistance services for eligible individuals

who elect such services pursuant to section three hundred sixty-five-f of the social services law; and

[(i)] (ix) that the applicant is financially responsible and may be expected to meet its obligations to its enrolled members.

(b) Notwithstanding paragraph (a) of this subdivision, the approval of any application for certification as a managed long term care plan under this section for a plan that seeks to cover a population of enrollees eligible for services under title XIX of the federal social security act, shall be subject to and conditioned on selection through the competitive bid process provided under subdivision six of this section.

§ 7. Subdivision 6 of section 4403-f of the public health law, as amended by section 41-b of part H of chapter 59 of the laws of 2011, paragraph (a) as amended by section 2 of part I of chapter 57 of the laws of 2023, paragraphs (d), (e), and (f) as added by section 5 of part MM of chapter 56 of the laws of 2020, and the opening paragraph of subparagraph (i) of paragraph (d) as amended by section 3 of part I of chapter 57 of the laws of 2023, is amended to read as follows:

6. Approval authority. [(a)] An applicant shall be issued a certificate of authority as a managed long term care plan upon a determination by the commissioner that the applicant complies with the operating requirements for a managed long term care plan under this section; provided, however, that any managed long term care plan seeking to provide health and long term care services to a population of enrollees that are eligible under title XIX of the federal social security act shall not receive a certificate of authority, nor be eligible for a contract to provide such services with the department, unless selected through the competitive bid process described in this subdivision. [The

commissioner shall issue no more than seventy-five certificates of authority to managed long term care plans pursuant to this section.

(a-1) Nothing in this section shall be construed as requiring the department to contract with or to contract for a particular line of business with an entity certified under this section for the provision of services available under title eleven of article five of the social services law. A managed long term care plan that has been issued a certificate of authority, or an applicant for a certificate of authority as a managed long term care plan that has in any of the three calendar years immediately preceding the application, met any of the following criteria shall not be eligible for a contract for the provision of services available under title eleven of article five of the social services law: (i) classified as a poor performer, or substantially similar terminology, by the centers for medicare and medicaid services; or (ii) an excessive volume of penalties, statements of findings, statements of deficiency, intermediate sanctions or enforcement actions, regardless of whether the applicant has addressed such issues in a timely manner.

(b) An operating demonstration shall be issued a certificate of authority as a managed long term care plan upon a determination by the commissioner that such demonstration complies with the operating requirements for a managed long term care plan under this section. Nothing in this section shall be construed to affect the continued legal authority of an operating demonstration to operate its previously approved program.

(c) For the period beginning April first, two thousand twelve and ending March thirty-first, two thousand fifteen, the majority leader of the senate and the speaker of the assembly may each recommend to the

commissioner, in writing, up to four eligible applicants to convert to be approved managed long term care plans. An applicant shall only be approved and issued a certificate of authority if the commissioner determines that the applicant meets the requirements of subdivision three of this section. The majority leader of the senate or the speaker of the assembly may assign their authority to recommend one or more applicants under this section to the commissioner]

(a) Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law, sections one hundred forty-two and one hundred forty-three of the economic development law, and any other inconsistent provision of law, the commissioner shall, through a competitive bid process based on proposals submitted to the department, provide for the selection of qualified managed long term care plans to provide health and long term care services to enrollees who are eligible under title XIX of the federal social security act pursuant to a contract with the department; provided, however, that:

(i) A proposal submitted by a managed long term care plan shall include information sufficient to allow the commissioner to evaluate the bidder in accordance with the requirements identified in subdivisions two, three and four of this section.

(ii) In addition to the criteria described in subparagraph (i) of this paragraph, the commissioner shall also consider:

(A) accessibility and geographic distribution of network providers, taking into account the needs of persons with disabilities and the differences between rural, suburban, and urban settings;

(B) the extent to which major public hospitals are included in the submitted provider network;

(C) demonstrated cultural and language competencies specific to the population of participants;

(D) the corporate organization and status of the bidder as a charitable corporation under the not-for-profit corporation law;

(E) the ability of a bidder to offer plans in multiple regions;

(F) the type and number of products the bidder proposes to operate, including products applied for in accordance with the provisions of subdivision five of section three hundred sixty-four-j of the social services law, and other products determined by the commissioner, including but not necessarily limited to those operated under title one-A of article twenty-five of this chapter and section three hundred sixty-nine-gg of the social services law;

(G) whether the bidder participates in products for integrated care for participants who are dually eligible for Medicaid and medicare;

(H) whether the bidder participates in value based payment arrangements as defined by the department, including the delegation of significant financial risk to clinically integrated provider networks;

(I) the bidder's commitment to participation in managed care in the state;

(J) the bidder's commitment to quality improvement;

(K) the bidder's commitment to community reinvestment spending, as shall be defined in the procurement;

(L) for current or previously authorized managed care providers, past performance in meeting managed care contract or federal or state requirements, and if the commissioner issued any statements of findings, statements of deficiency, intermediate sanctions or enforcement actions to a bidder for non-compliance with such requirements, whether the bidder addressed such issues in a timely manner; and

(M) any other criteria deemed appropriate by the commissioner.

(iii) Subparagraphs (i) and (ii) of this paragraph describing proposal content and selection criteria requirements shall not be construed as limiting or requiring the commissioner to evaluate such content or criteria on a pass/fail scale, or other particular methodological basis; provided however, that the commissioner must consider all such content and criteria using methods determined by the commissioner in their discretion and, as applicable, in consultation with the commissioners of the office of mental health, the office for people with developmental disabilities, the office of addiction services and supports, and the office of children and family services.

(iv) The department shall post on its website:

(A) The request for proposals and a description of the proposed services to be provided pursuant to contracts in accordance with this subdivision;

(B) The criteria on which the department shall determine qualified bidders and evaluate their applications, including all criteria identified in this subdivision;

(C) The manner by which a proposal may be submitted, which may include submission by electronic means;

(D) The manner by which a managed long term care plan may continue to provide health and long term care services to enrollees who are eligible under title XIX of the federal social security act pending awards to managed long term care plans through a competitive bid process pursuant to this subdivision; and

(E) Upon award, the managed long term care plans that the commissioner intends to contract with pursuant to this subdivision, provided that the

commissioner shall update such list to indicate the final slate of contracted managed long term care plans.

(v) (A) All responsible and responsive submissions that are received from bidders in a timely fashion shall be reviewed by the commissioner in consultation with the commissioners of the office of mental health, the office for people with developmental disabilities, the office of addiction services and supports, and the office of children and family services, as applicable. The commissioner shall consider comments resulting from the review of proposals and make awards in consultation with such agencies.

(B) The commissioner may make awards under this subdivision, for each product for which proposals were requested, to two or more managed long term care plans in each geographic region defined by the commissioner in the request for proposals for which at least two managed long term care plans have submitted a proposal, and shall have discretion to offer more contracts based on need for access.

(C) Managed long term care plans awarded under this subdivision shall be entitled to enter into a contract with the department for the purpose of providing health and long term care services to enrollees who are eligible under title XIX of the federal social security act. Such contracts shall run for a term to be determined by the commissioner, which may be renewed or modified from time to time without a new request for proposals, to ensure consistency with changes in federal and state laws, regulations and policies, including but not limited to the expansion or reduction of medical assistance services available to the participants through a managed long term care plan.

(D) Nothing in this paragraph or other provision of this section shall be construed to limit in any way the ability of the department to termi-

nate awarded contracts for cause, which shall include but not be limited to any violation of the terms of such contracts or violations of state or federal laws and regulations and any loss of necessary state or federal funding.

(E) Nothing in this paragraph or other provision of this section shall be construed to limit in any way the ability of the department to issue a new request for proposals for a term following an existing term of an award.

(b) Addressing needs for additional managed long term care plans to ensure access and choice for enrollees eligible under title XIX of the federal social security act. If necessary to ensure access to a sufficient number of managed long term care plans on a geographic or other basis, including a lack of adequate and appropriate care, language and cultural competence, or special needs services, the commissioner may reissue a request for proposals as provided for under paragraph (a) of this subdivision, provided however that such request may be limited to the geographic or other basis of need that the request for proposals seeks to address. Any awards made shall be subject to the requirements of this section, including but not limited to the minimum and maximum number of awards in a region.

[(d)] (c) (i) Effective April first, two thousand twenty, and expiring [March thirty-first, two thousand twenty-seven] on the date the commissioner publishes on the department's website a request for proposals in accordance with subparagraph (iv) of paragraph (a) of this subdivision, the commissioner shall place a moratorium on the processing and approval of applications seeking a certificate of authority as a managed long term care plan pursuant to this section, including applications seeking authorization to expand an existing managed long term care plan's

approved service area or scope of eligible enrollee populations. Such moratorium shall not apply to:

(A) applications submitted to the department prior to January first, two thousand twenty;

(B) applications seeking approval to transfer ownership or control of an existing managed long term care plan;

(C) applications demonstrating to the commissioner's satisfaction that submission of the application for consideration would be appropriate to address a serious concern with care delivery, such as a lack of adequate access to managed long term care plans in a geographic area or a lack of adequate and appropriate care, language and cultural competence, or special needs services; and

(D) applications seeking to operate under the PACE (Program of All-Inclusive Care for the Elderly) model as authorized by federal public law 105-33, subtitle I of title IV of the Balanced Budget Act of 1997, or to serve individuals dually eligible for services and benefits under titles XVIII and XIX of the federal social security act in conjunction with an affiliated Medicare Dual Eligible Special Needs Plan, based on the need for such plans and the experience of applicants in serving dually eligible individuals as determined by the commissioner in their discretion.

(ii) For the duration of the moratorium, the commissioner shall assess the public need for managed long term care plans that are not integrated with an affiliated Medicare plan, the ability of such plans to provide high quality and cost effective care for their membership, and based on such assessment develop a process and conduct an orderly wind-down and elimination of such plans, which shall coincide with the expiration of the moratorium unless the commissioner determines that a longer wind-down period is needed.

[(e) For the duration of the moratorium under paragraph (d) of this subdivision] (d) From April first, two thousand twenty, until March thirty-first, two thousand twenty-four, the commissioner shall establish, and enforce by means of a premium withholding equal to three percent of the base rate, an annual cap on total enrollment (enrollment cap) for each managed long term care plan, subject to subparagraphs (ii) and (iii) of this paragraph, based on a percentage of each plan's reported enrollment as of October first, two thousand twenty.

(i) The specific percentage of each plan's enrollment cap shall be established by the commissioner based on: (A) the ability of individuals eligible for such plans to access health and long term care services, (B) plan quality of care scores, (C) historical plan disenrollment, (D) the projected growth of individuals eligible for such plans in different regions of the state, (E) historical plan enrollment of patients with varying levels of need and acuity, and (F) other factors in the commissioner's discretion to ensure compliance with federal requirements, appropriate access to plan services, and choice by eligible individuals.

(ii) In the event that a plan exceeds its annual enrollment cap, the commissioner is authorized under this paragraph to retain all or a portion of the premium withheld based on the amount over which a plan exceeds its enrollment cap. Penalties assessed pursuant to this subdivision shall be determined by regulation.

(iii) The commissioner may not establish an annual cap on total enrollment under this paragraph for plans' lines of business operating under the PACE (Program of All-Inclusive Care for the Elderly) model as authorized by federal public law 105-33, subtitle I of title IV of the Balanced Budget Act of 1997, or that serve individuals dually eligible for services and benefits under titles XVIII and XIX of the federal

social security act in conjunction with an affiliated Medicare Dual Eligible Special Needs Plan.

[(f) In implementing the provisions of paragraphs (d) and (e) of this subdivision, the commissioner shall, to the extent practicable, consider and select methodologies that seek to maximize continuity of care and minimize disruption to the provider labor workforce, and shall, to the extent practicable and consistent with the ratios set forth herein, continue to support contracts between managed long term care plans and licensed home care services agencies that are based on a commitment to quality and value.]

§ 8. Section 1 of part I of chapter 57 of the laws of 2022, providing a one percent across the board payment increase to all qualifying fee-for-service Medicaid rates, is amended by adding two new subdivisions 3 and 4 to read as follows:

3. For the state fiscal years beginning April 1, 2024, and thereafter, all department of health Medicaid payments made to Medicaid managed care organizations will no longer be subject to the uniform rate increase in subdivision one of this section.

4. Rate adjustments made pursuant to subdivisions one through three of this section shall not be subject to the notification requirements set forth in subdivision 7 of section 2807 of the public health law.

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

40. (a) The commissioner shall be entitled to recover liquidated damages from managed care organizations for failure to meet the contractual obligations and performance standards of their contract.

(b) The commissioner shall have sole discretion in determining whether to impose a recovery of the financial loss and damages for noncompliance with any provision of the contract.

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

(ii) Any liquidated damages findings as a result of the review required by this subdivision shall be due and payable sixty calendar days from the issuance of a statement of damages regardless of any dispute in the amount or interpretation of the amount due contained in the notice.

(iii) The commissioner may elect, in their sole discretion, to collect damages imposed by this section from, and as a set off against, payments due to the managed care organization, or payments that becomes due any time after the calculation of liquidated damages. Deductions shall continue until the full amount of the noticed damages are paid in full.

(iv) All liquidated damages imposed by this subdivision shall be paid out of the administrative costs and profits of the managed care organization.

(v) The managed care organization shall not pass the liquidated damages imposed under this subdivision through to any provider and/or subcontractor.

(d) (i) To dispute liquidated damages imposed by this subdivision the managed care organization must submit a written request of its dispute to the commissioner within thirty calendar days from the date of the statement of damages. Such dispute shall be made in the form and manner prescribed by the commissioner.

(ii) The department will deny any disputes that are not delivered in the format and timeframe specified by the department.

(iii) The managed care organization waives any dispute not raised within thirty calendar days of issuance of the statement of damages. It also waives any arguments it fails to raise in writing within thirty calendar days of issuance of the statement of damages, and waives the right to use any materials, data, and/or information not contained in or accompanying the managed care organization's submission submitted within the thirty calendar days of issuance of the statement of damages in any subsequent legal or administrative proceeding.

(iv) The commissioner or their designee shall decide the dispute, reduce the decision to writing and issue their decision to the managed care organization within ninety calendar days of receipt of the dispute. This written decision shall be final.

(e) For purposes of this subdivision a violation shall mean a determination by the commissioner that the managed care organization failed to act as required under the model contract or applicable federal and state statutes, rules or regulations governing managed care organization. For the purposes of this subdivision, each day that an ongoing violation continues shall be a separate violation. In addition, each instance of failing to furnish necessary and/or required medical services or items to each enrollee shall be a separate violation. As well, each day that the managed care organization fails to furnish necessary and/or required medical services or items to enrollees shall be a separate violation.

(f) For purposes of this subdivision managed care organization shall mean any managed care organizations subject to this section and article forty-four of the public health law, including managed long term care plans.

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

§ 10. This act shall not be construed to prohibit managed care providers participating in the managed care program and managed long term care plans approved to provide health and long term care services to enrollees who are eligible under title XIX of the federal social security act, that were so authorized as of the effective date of this act from continuing operations as authorized until such time as awards are made in accordance with this act and such additional time subject to direction from the commissioner of health to ensure the safe and orderly transfer of participants.

§ 11. This act shall take effect immediately and shall apply to disputes filed with the superintendent of financial services pursuant to article six of the financial services law on or after such effective date; provided that:

(a) the amendments to section 364-j of the social services law made by sections two, three and nine of this act shall not affect the repeal of such section and shall be deemed repealed therewith; and

(b) the amendments to section 4403-f of the public health law made by sections five, six and seven of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART I

Section 1. Paragraph (a) of subdivision 4 of section 365-a of the social services law, as amended by chapter 493 of the laws of 2010, is amended to read as follows:

(a) drugs which may be dispensed without a prescription as required by section sixty-eight hundred ten of the education law; provided, however, that the state commissioner of health may by regulation specify certain of such drugs which may be reimbursed as an item of medical assistance in accordance with the price schedule established by such commissioner. Notwithstanding any other provision of law, [additions] modifications to the list of drugs reimbursable under this paragraph may be filed as regulations by the commissioner of health without prior notice and comment;

§ 2. Paragraph (b) of subdivision 3 of section 273 of the public health law, as added by section 10 of part C of chapter 58 of the laws of 2005, is amended to read as follows:

(b) In the event that the patient does not meet the criteria in paragraph (a) of this subdivision, the prescriber may provide additional information to the program to justify the use of a prescription drug that is not on the preferred drug list. The program shall provide a reasonable opportunity for a prescriber to reasonably present his or her justification of prior authorization. [If, after consultation with the program, the prescriber, in his or her reasonable professional judgment, determines that] The program will consider the additional information and the justification presented to determine whether the use of a prescription drug that is not on the preferred drug list is warranted, and the [prescriber's] program's determination shall be final.

§ 3. Subdivisions 25 and 25-a of section 364-j of the social services law are REPEALED.

§ 4. Section 280 of the public health law, as amended by section 8 of part D of chapter 57 of the laws of 2018, paragraph (b) of subdivision 2 as amended by section 5, subdivision 3 as amended by section 6, para-

graph (a) of subdivision 5 as amended by section 7, subparagraph (iii) of paragraph (e) as amended by section 6-a and subdivision 8 as amended by section 9 of part B of chapter 57 of the laws of 2019, paragraphs (c) and (d) of subdivision 2 as amended and paragraph (e) of subdivision 2 as added by section 2 of part FFF of chapter 56 of the laws of 2020, the opening paragraph of paragraph (a) of subdivision 6 and paragraph (a) of subdivision 7 as amended by sections 3 and 4, respectively, of part GG of chapter 56 of the laws of 2020, is amended to read as follows:

§ 280. Medicaid drug cap. 1. The legislature hereby finds and declares that there is a significant public interest for the Medicaid program to manage drug costs in a manner that ensures patient access while providing financial stability for the state and participating providers. Since two thousand eleven, the state has taken significant steps to contain costs in the Medicaid program by imposing a statutory limit on annual growth. Drug expenditures, however, continually outpace other cost components causing significant pressure on the state, providers, and patient access operating under the Medicaid global cap. It is therefore intended that the department establish a [Medicaid drug cap as a separate component within the Medicaid global cap] <u>supplemental rebate program</u> as part of a focused and sustained effort to balance the growth of drug expenditures with the growth of total Medicaid expenditures.

2. The commissioner shall [establish a year to year] <u>review at least annually the</u> department of health state funds Medicaid drug [expenditure growth target as follows:

(a) for state fiscal year two thousand seventeen--two thousand eighteen, be limited to the ten-year rolling average of the medical compo-

nent of the consumer price index plus five percent and minus a pharmacy savings target of fifty-five million dollars; and

(b) for state fiscal year two thousand eighteen--two thousand nineteen, be limited to the ten-year rolling average of the medical component of the consumer price index plus four percent and minus a pharmacy savings target of eighty-five million dollars;

(c) for state fiscal year two thousand nineteen--two thousand twenty, be limited to the ten-year rolling average of the medical component of the consumer price index plus four percent and minus a pharmacy savings target of eighty-five million dollars;

(d) for state fiscal year two thousand twenty--two thousand twenty-one, be limited to the ten-year rolling average of the medical component of the consumer price index plus two percent; and

(e) for state fiscal year two thousand twenty-one--two thousand twenty-two and fiscal years thereafter, be limited in accordance with subdivision one of section ninety-one of part H of chapter fifty-nine of the laws of two thousand eleven, as amended] expenditures to identify drugs, including but not limited to, drugs in the eightieth percentile or higher of total spend, net of rebate or in the eightieth percentile or higher based on cost per claim, net of rebate.

3. (a) The [department and the division of the budget shall assess on a quarterly basis the projected total amount to be expended in the year on a cash basis by the Medicaid program for each drug, and the projected annual amount of state funds Medicaid drug expenditures on a cash basis for all drugs, which shall be a component of the projected department of health state funds Medicaid expenditures calculated for purposes of sections ninety-one and ninety-two of part H of chapter fifty-nine of the laws of two thousand eleven. For purposes of this section, state

funds Medicaid drug expenditures include amounts expended for drugs in both the Medicaid fee-for-service program and Medicaid managed care programs, minus the amount of any drug rebates or supplemental drug rebates received by the department, including rebates pursuant to subdivision five of this section with respect to rebate targets. The department and the division of the budget shall report in December of each year, for the prior April through October, to the drug utilization review board the projected state funds Medicaid drug expenditures including the amounts, in aggregate thereof, attributable to the net cost of: changes in the utilization of drugs by Medicaid recipients; changes in the number of Medicaid recipients; changes to the cost of brand name drugs and changes to the cost of generic drugs. The information contained in the report shall not be publicly released in a manner that allows for the identification of an individual drug or manufacturer or that is likely to compromise the financial competitive, or proprietary nature of the information.

(a) In the event the director of the budget determines, based on Medicaid drug expenditures for the previous quarter or other relevant information, that the total department of health state funds Medicaid drug expenditure is projected to exceed the annual growth limitation imposed by subdivision two of this section, the] commissioner may identify and refer drugs, including but not limited to, drugs in the eightieth percentile or higher of total spend, net of rebate or in the eightieth percentile or higher based on cost per claim, net of rebate, to the drug utilization review board established by section three hundred sixty-nine-bb of the social services law for a recommendation as to whether a target supplemental Medicaid rebate should be paid by the manufacturer of the drug to the department and the target amount of the rebate.

(b) If the department intends to refer a drug to the drug utilization review board pursuant to paragraph (a) of this subdivision, the department shall notify the manufacturer of such drug and shall attempt to reach agreement with the manufacturer on a rebate for the drug prior to referring the drug to the drug utilization review board for review. Such rebate may be based on evidence-based research, including, but not limited to, such research operated or conducted by or for other state governments, the federal government, the governments of other nations, and third party payers or multi-state coalitions, provided however that the department shall account for the effectiveness of the drug in treating the conditions for which it is prescribed or in improving a patient's health, quality of life, or overall health outcomes, and the likelihood that use of the drug will reduce the need for other medical care, including hospitalization.

(c) In the event that the commissioner and the manufacturer have previously agreed to a supplemental rebate for a drug pursuant to paragraph (b) of this subdivision or paragraph (e) of subdivision seven of section three hundred sixty-seven-a of the social services law, the drug shall not be referred to the drug utilization review board for any further supplemental rebate for the duration of the previous rebate agreement, provided however, the commissioner may refer a drug to the drug utilization review board if the commissioner determines there are significant and substantiated utilization or market changes, new evidence-based research, or statutory or federal regulatory changes that warrant additional rebates. In such cases, the department shall notify the manufacturer and provide evidence of the changes or research that would warrant additional rebates, and shall attempt to reach agreement

with the manufacturer on a rebate for the drug prior to referring the drug to the drug utilization review board for review.

(d) The department shall consider a drug's actual cost to the state, including current rebate amounts, prior to seeking an additional rebate pursuant to paragraph (b) or (c) of this subdivision.

(e) [The commissioner shall be authorized to take the actions described in this section only so long as total Medicaid drug expenditures are projected to exceed the annual growth limitation imposed by subdivision two of this section.] If the commissioner is unsuccessful in entering into a rebate arrangement with the manufacturer of the drug satisfactory to the department, the drug manufacturer shall, in that event be required to provide to the department, on a standard reporting form developed by the department, the following information:

(i) the actual cost of developing, manufacturing, producing (including the cost per dose of production), and distributing the drug;

(ii) research and development costs of the drug, including payments to predecessor entities conducting research and development, such as biotechnology companies, universities and medical schools, and private research institutions;

(iii) administrative, marketing, and advertising costs for the drug, apportioned by marketing activities that are directed to consumers, marketing activities that are directed to prescribers, and the total cost of all marketing and advertising that is directed primarily to consumers and prescribers in New York, including but not limited to prescriber detailing, copayment discount programs, and direct-to-consumer marketing;

(iv) the extent of utilization of the drug;

(v) prices for the drug that are charged to purchasers outside the United States;

(vi) prices charged to typical purchasers in the state, including but not limited to pharmacies, pharmacy chains, pharmacy wholesalers, or other direct purchasers;

(vii) the average rebates and discounts provided per payer type in the state; and

(viii) the average profit margin of each drug over the prior five-year period and the projected profit margin anticipated for such drug.

(f) All information disclosed pursuant to paragraph (e) of this subdivision shall be considered confidential and shall not be disclosed by the department in a form that identifies a specific manufacturer or prices charged for drugs by such manufacturer.

4. In determining whether to recommend a target supplemental rebate for a drug, the drug utilization review board shall consider the actual cost of the drug to the Medicaid program, including federal and state rebates, and may consider, among other things:

(a) the drug's impact on the Medicaid drug spending growth target and the adequacy of capitation rates of participating Medicaid managed care plans, and the drug's affordability and value to the Medicaid program; or

(b) significant and unjustified increases in the price of the drug; or

(c) whether the drug may be priced disproportionately to its therapeutic benefits.

5. (a) If the drug utilization review board recommends a target rebate amount on a drug referred by the commissioner, the department shall negotiate with the drug's manufacturer for a supplemental rebate to be paid by the manufacturer in an amount not to exceed such target rebate

amount. [A rebate requirement shall apply beginning with the first day of the state fiscal year during which the rebate was required without regard to the date the department enters into the rebate agreement with the manufacturer.]

(b) The supplemental rebate required by paragraph (a) of this subdivision shall apply to drugs dispensed to enrollees of managed care providers pursuant to section three hundred sixty-four-j of the social services law and to drugs dispensed to Medicaid recipients who are not enrollees of such providers.

(c) [If the drug utilization review board recommends a target rebate amount for a drug and the department is unable to negotiate a rebate from the manufacturer in an amount that is at least seventy-five percent of the target rebate amount, the commissioner is authorized to waive the provisions of paragraph (b) of subdivision three of section two hundred seventy-three of this article and the provisions of subdivisions twenty-five and twenty-five-a of section three hundred sixty-four-j of the social services law with respect to such drug; however, this waiver shall not be implemented in situations where it would prevent access by a Medicaid recipient to a drug which is the only treatment for a particular disease or condition. Under no circumstances shall the commissioner be authorized to waive such provisions with respect to more than two drugs in a given time.

(d)] Where the department and a manufacturer enter into a rebate agreement pursuant to this section, which may be in addition to existing rebate agreements entered into by the manufacturer with respect to the same drug, no additional rebates shall be required to be paid by the manufacturer to a managed care provider or any of a managed care provid-

er's agents, including but not limited to any pharmacy benefit manager, while the department is collecting the rebate pursuant to this section.

[(e)] (d) In formulating a recommendation concerning a target rebate amount for a drug, the drug utilization review board may consider:

(i) publicly available information relevant to the pricing of the drug;

(ii) information supplied by the department relevant to the pricing of the drug;

(iii) information relating to value-based pricing provided, however, if the department directly invites any third party to provide cost-effectiveness analysis or research related to value-based pricing, and the department receives and considers such analysis or research for use by the board, such third party shall disclose any funding sources. The department shall, if reasonably possible, make publicly available the following documents in its possession that it relies upon to provide cost effectiveness analyses or research related to value-based pricing: (A) descriptions of underlying methodologies; (B) assumptions and limitations of research findings; and (C) if available, data that presents results in a way that reflects different outcomes for affected subpopulations;

(iv) the seriousness and prevalence of the disease or condition that is treated by the drug;

(v) the extent of utilization of the drug;

(vi) the effectiveness of the drug in treating the conditions for which it is prescribed, or in improving a patient's health, quality of life, or overall health outcomes;

(vii) the likelihood that use of the drug will reduce the need for other medical care, including hospitalization;

(viii) the average wholesale price, wholesale acquisition cost, retail price of the drug, and the cost of the drug to the Medicaid program minus rebates received by the state;

(ix) in the case of generic drugs, the number of pharmaceutical manufacturers that produce the drug;

(x) whether there are pharmaceutical equivalents to the drug; and

(xi) information supplied by the manufacturer, if any, explaining the relationship between the pricing of the drug and the cost of development of the drug and/or the therapeutic benefit of the drug, or that is otherwise pertinent to the manufacturer's pricing decision; any such information, including the information on the standard reporting form requirement in paragraph (e) of subdivision three of this section, provided shall be considered confidential and shall not be disclosed by the drug utilization review board in a form that identifies a specific manufacturer or prices charged for drugs by such manufacturer.

6. [(a) If the drug utilization review board recommends a target rebate amount or if the commissioner identifies a drug as a high cost drug pursuant to subparagraph (vii) of paragraph (e) of subdivision 7 of section three hundred sixty-seven-a of the social services law and the department is unsuccessful in entering into a rebate arrangement with the manufacturer of the drug satisfactory to the department, the drug manufacturer shall in that event be required to provide to the department, on a standard reporting form developed by the department, the following information:

(i) the actual cost of developing, manufacturing, producing (including the cost per dose of production), and distributing the drug;

(ii) research and development costs of the drug, including payments to predecessor entities conducting research and development, such as

biotechnology companies, universities and medical schools, and private research institutions;

(iii) administrative, marketing, and advertising costs for the drug, apportioned by marketing activities that are directed to consumers, marketing activities that are directed to prescribers, and the total cost of all marketing and advertising that is directed primarily to consumers and prescribers in New York, including but not limited to prescriber detailing, copayment discount programs, and direct-to-consumer marketing;

(iv) the extent of utilization of the drug;

(v) prices for the drug that are charged to purchasers outside the United States;

(vi) prices charged to typical purchasers in the state, including but not limited to pharmacies, pharmacy chains, pharmacy wholesalers, or other direct purchasers;

(vii) the average rebates and discounts provided per payer type in the State; and

(viii) the average profit margin of each drug over the prior five-year period and the projected profit margin anticipated for such drug.

(b) All information disclosed pursuant to paragraph (a) of this subdivision shall be considered confidential and shall not be disclosed by the department in a form that identifies a specific manufacturer or prices charged for drugs by such manufacturer.

7.] (a) [If, after] <u>After</u> taking into account all rebates and supplemental rebates received by the department, including rebates received to date pursuant to this section[, total Medicaid drug expenditures are still projected to exceed the annual growth limitation imposed by subdivision two of this section], the commissioner may: subject any drug of a

manufacturer referred to the drug utilization review board under this section to prior approval in accordance with existing processes and procedures when such manufacturer has not entered into a supplemental rebate arrangement as required by this section; direct a managed care plan to limit or reduce reimbursement for a drug provided by a medical practitioner if the drug utilization review board recommends a target rebate amount for such drug and the manufacturer has failed to enter into a rebate arrangement required by this section; direct managed care plans to remove from their Medicaid formularies any drugs of a manufacturer who has a drug that the drug utilization review board recommends a target rebate amount for and the manufacturer has failed to enter into a rebate arrangement required by this section; promote the use of cost effective and clinically appropriate drugs other than those of a manufacturer who has a drug that the drug utilization review board recommends a target rebate amount and the manufacturer has failed to enter into a rebate arrangement required by this section; allow manufacturers to accelerate rebate payments under existing rebate contracts; and such other actions as authorized by law. [The commissioner shall provide written notice to the legislature thirty days prior to taking action pursuant to this paragraph, unless action is necessary in the fourth quarter of a fiscal year to prevent total Medicaid drug expenditures from exceeding the limitation imposed by subdivision two of this section, in which case such notice to the legislature may be less than thirty days.]

(b) The commissioner shall be authorized to take the actions described in paragraph (a) of this subdivision [only so long as total Medicaid drug expenditures are projected to exceed the annual growth limitation imposed by subdivision two of this section]. In addition, no such

actions shall be deemed to supersede the provisions of paragraph (b) of subdivision three of section two hundred seventy-three of this article or the provisions of subdivisions twenty-five and twenty-five-a of section three hundred sixty-four-j of the social services law[, except as allowed by paragraph (c) of subdivision five of this section]; provided further that nothing in this section shall prevent access by a Medicaid recipient to a drug which is the only treatment for a particular disease or condition.

[8.] 7. The commissioner, upon request of the chair of the drug utilization review board, shall provide a report [by July first annually to the drug utilization review board] on savings achieved through the drug cap in the last fiscal year. Such report shall provide data on what savings were achieved [through actions pursuant to subdivisions three, five and seven of this section, respectively, and what savings were achieved through other means] and how such savings were calculated and implemented.

§ 5. Paragraph (e) of subdivision 7 of section 367-a of the social services law, as amended by section 1 of part GG of chapter 56 of the laws of 2020, the opening paragraph as amended by section 24 of part B of chapter 57 of the laws of 2023, is amended to read as follows:

(e) During the period from April first, two thousand fifteen through March thirty-first, two thousand twenty-six, the commissioner may, in lieu of a managed care provider or pharmacy benefit manager, negotiate directly and enter into an arrangement with a pharmaceutical manufacturer for the provision of supplemental rebates relating to pharmaceutical utilization by enrollees of managed care providers pursuant to section three hundred sixty-four-j of this title and may also negotiate directly and enter into such an agreement relating to pharmaceutical utilization

by medical assistance recipients not so enrolled. Such rebate arrangements shall be limited to the following: antiretrovirals approved by the FDA for the treatment of HIV/AIDS, accelerated approval drugs established pursuant to subparagraph (ix) of this paragraph, opioid dependence agents and opioid antagonists listed in a statewide formulary established pursuant to subparagraph (vii) of this paragraph, hepatitis C agents, high cost drugs as provided for in subparagraph (viii) of this paragraph, gene therapies as provided for in subparagraph (ix) of this paragraph, and any other class or drug designated by the commissioner for which the pharmaceutical manufacturer has in effect a rebate arrangement with the federal secretary of health and human services pursuant to 42 U.S.C. § 1396r-8, and for which the state has established standard clinical criteria. No agreement entered into pursuant to this paragraph shall have an initial term or be extended beyond the expiration or repeal of this paragraph.

(i) The manufacturer shall not enter into any rebate arrangements with a managed care provider, or any of a managed care provider's agents, including but not limited to any pharmacy benefit manager on the gene therapy, drug, or drug classes subject to this paragraph when the state has a rebate arrangement in place and standard clinical criteria are imposed on the managed care provider.

(ii) The commissioner shall establish adequate rates of reimbursement which shall take into account both the impact of the commissioner negotiating such arrangements and any limitations imposed on the managed care provider's ability to establish clinical criteria relating to the utilization of such drugs. In developing the managed care provider's reimbursement rate, the commissioner shall identify the amount of reimbursement for such drugs as a separate and distinct component from

the reimbursement otherwise made for prescription drugs as prescribed by this section.

(iii) [The commissioner shall submit a report to the temporary president of the senate and the speaker of the assembly annually by December thirty-first. The report shall analyze the adequacy of rates to managed care providers for drug expenditures related to the classes under this paragraph.

(iv)] Nothing in this paragraph shall be construed to require a pharmaceutical manufacturer to enter into a rebate arrangement satisfactory to the commissioner relating to pharmaceutical utilization by enrollees of managed care providers pursuant to section three hundred sixty-four-j of this title or relating to pharmaceutical utilization by medical assistance recipients not so enrolled.

[(v)] (iv) All clinical criteria, including requirements for prior approval, and all utilization review determinations established by the state as described in this paragraph for the gene therapies, drugs, or drug classes subject to this paragraph shall be developed using evidence-based and peer-reviewed clinical review criteria in accordance with article two-A of the public health law, as applicable.

[(vi)] (v) All prior authorization and utilization review determinations related to the coverage of any drug subject to this paragraph shall be subject to article forty-nine of the public health law, section three hundred sixty-four-j of this title, and article forty-nine of the insurance law, as applicable. Nothing in this paragraph shall diminish any rights relating to access, prior authorization, or appeal relating to any drug class or drug afforded to a recipient under any other provision of law.

[(vii)] (vi) The department shall publish a statewide formulary of opioid dependence agents and opioid antagonists, which shall include as "preferred drugs" all drugs in such classes, which shall include all subclasses of a given drug that have a different pharmacological route of administration, provided that:

(A) for all drugs that are included as of the date of the enactment of this subparagraph on a formulary of a managed care provider, as defined in section three hundred sixty-four-j of this title, or in the Medicaid fee-for-service preferred drug program pursuant to section two hundred seventy-two of the public health law, the cost to the department for such drug is equal to or less than the lowest cost paid for the drug by any managed care provider or by the Medicaid fee-for-service program after the application of any rebates, as of the date that the department implements the statewide formulary established by this subparagraph. Where there is a generic version of the drug approved by the Food and Drug Administration as bioequivalent to a brand name drug pursuant to 21 U.S.C. § 355(j)(8)(B), the cost to the department for the brand and generic versions shall be equal to or less than the lower of the two maximum costs determined pursuant to the previous sentence; and

(B) for all drugs that are not included as of the date of the enactment of this subparagraph on a formulary of a managed care provider, as defined in section three hundred sixty-four-j of this title, or in the Medicaid fee-for-service preferred drug program pursuant to section two hundred seventy-two of the public health law, the department is able to obtain the drug at a cost that is equal to or less than the lowest cost to the department of other comparable drugs in the class, after the application of any rebates. Where there is a generic version of the drug approved by the Food and Drug Administration as bioequivalent to a brand

name drug pursuant to 21 U.S.C. § 355(j)(8)(B), the cost to the department for the brand and generic versions shall be equal to or less than the lower of the two maximum costs determined pursuant to the previous sentence.

[(viii)] (vii) The commissioner may identify and refer high cost drugs, as defined in clause (D) of this subparagraph, that are not included as of the date of the enactment of this subparagraph on a formulary of a managed care provider or covered by the Medicaid fee for service of program to the drug utilization review board established by section three hundred sixty-nine-bb of this article for a recommendation as to whether a target supplemental Medicaid rebate should be paid by the manufacturer of the drug to the department and the target amount of the rebate.

(A) If the commissioner intends to refer a high cost drug to the drug utilization review board pursuant to this subparagraph, the commissioner shall notify the manufacturer of such drug and shall attempt to reach agreement with the manufacturer on a rebate arrangement satisfactory to the commissioner for the drug prior to referring the drug to the drug utilization review board for review. Such arrangement may be based on evidence based research, including, but not limited to, such research operated or conducted by or for other state governments, the federal government, the governments of other nations, and third party payers or multi-state coalitions, provided however that the department shall account for the effectiveness of the drug in treating the conditions for which it is prescribed or in improving a patient's health, quality of life, or overall health outcomes, and the likelihood that use of the drug will reduce the need for other medical care, including hospitalization.

(B) In the event that the commissioner and the manufacturer have previously agreed to a rebate arrangement for a drug pursuant to this paragraph, the drug shall not be referred to the drug utilization review board for any further rebate agreement for the duration of the previous rebate agreement, provided however, the commissioner may refer a drug to the drug utilization review board if the commissioner determines there are significant and substantiated utilization or market changes, new evidence-based research, or statutory or federal regulatory changes that warrant additional rebates. In such cases, the department shall notify the manufacturer and provide evidence of the changes or research that would warrant additional rebates, and shall attempt to reach agreement with the manufacturer on a rebate for the drug prior to referring the drug to the drug utilization review board for review.

(C) If the commissioner is unsuccessful in entering into a rebate arrangement with the manufacturer of the drug satisfactory to the department, the drug manufacturer shall in that event be required to provide to the department, on a standard reporting form developed by the department, the information as described in paragraph (e) of subdivision [six] three of section two hundred eighty of the public health law. All information disclosed pursuant to this clause shall be considered confidential and shall not be disclosed by the department in a form that identifies a specific manufacturer or prices charged for drugs by such manufacturer.

(D) For the purposes of this subparagraph, the term "high cost drug" shall mean a brand name drug or biologic that has a launch wholesale acquisition cost of thirty thousand dollars or more per year or course of treatment, or a biosimilar drug that has a launch wholesale acquisition cost that is not at least fifteen percent lower than the referenced

brand biologic at the time the biosimilar is launched, or a generic drug that has a wholesale acquisition cost of one hundred dollars or more for a thirty day supply or recommended dosage approved for labeling by the federal Food and Drug Administration, or a brand name drug or biologic that has a wholesale acquisition cost increase of three thousand dollars or more in any twelve-month period, or course of treatment if less than twelve months.

[(ix)] (viii) For purposes of this paragraph, a "gene therapy" is a drug (A) approved under section 505 of the Federal Food, Drug and Cosmetics Act or licensed under subsection (a) or (k) of section 351 of the Public Health Services Act; (B) that treats a rare disease or condition, as defined in 21 USC § 360bb(a)(2), that is life-threatening, as defined in 42 CFR 321.18; (C) is considered a gene therapy by the federal Food and Drug Administration for which a biologics license pursuant to 21 CFR 600-680 is held; (D) if administered in accordance with the labeling of such drug, is expected to result in either the cure of such disease or condition or a reduction in the symptoms of such disease or condition that materially improves the patient's length or quality of life; and (E) is expected to achieve the result described in clause (D) of this subparagraph after not more than three administrations.

(ix) For purposes of this paragraph, an "accelerated approval" is a drug or labeled indication of a drug authorized by the Federal Food, Drug and Cosmetic Act for drugs for serious conditions that fill an unmet medical need based on whether the drug has an effect on a surrogate clinical endpoint, and contingent upon verification of clinical benefit in confirmatory trials.

§ 6. Paragraph (g) of subdivision 2 of section 365-a of the social services law, as amended by section 21 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

(g) sickroom supplies, eyeglasses, prosthetic appliances and dental prosthetic appliances furnished in accordance with the regulations of the department; provided further that: (i) the commissioner of health is authorized to implement a preferred diabetic supply program wherein the department of health will receive enhanced rebates from preferred manufacturers [of] for products and supplies, including but not limited to, glucometers and test strips, and may subject non-preferred manufacturers' products and supplies, including but not limited to, glucometers and test strips to prior authorization under section two hundred seventy-three of the public health law; (ii) enteral formula therapy and nutritional supplements are limited to coverage only for nasogastric, jejunostomy, or gastrostomy tube feeding, for treatment of an inborn metabolic disorder, or to address growth and development problems in children, or, subject to standards established by the commissioner, for persons with a diagnosis of HIV infection, AIDS or HIV-related illness or other diseases and conditions; (iii) prescription footwear and inserts are limited to coverage only when used as an integral part of a lower limb orthotic appliance, as part of a diabetic treatment plan, or to address growth and development problems in children; (iv) compression and support stockings are limited to coverage only for pregnancy or treatment of venous stasis ulcers; and (v) the commissioner of health is authorized to implement an incontinence supply utilization management program to reduce costs without limiting access through the existing provider network, including but not limited to single or multiple source contracts or, a preferred incontinence supply program wherein the

department of health will receive enhanced rebates from preferred manufacturers of incontinence supplies, and may subject non-preferred manufacturers' incontinence supplies to prior approval pursuant to regulations of the department, provided any necessary approvals under federal law have been obtained to receive federal financial participation in the costs of incontinence supplies provided pursuant to this subparagraph;

§ 7. The public health law is amended by adding a new section 280-d to read as follows:

§ 280-d. Pharmacy cost reporting. 1. The department shall develop and implement a cost reporting program for licensed pharmacies that participate in the Medicaid program. Such program shall include a requirement to submit an annual cost report on a form designated by the department. Information shall include, but not be limited to, costs incurred during procurement and dispensing of prescription drugs.

2. Such cost reports are subject to audit. In the event that any information or data which a pharmacy has submitted to the department, on the required reporting forms is inaccurate or incorrect, such pharmacy shall within fifteen business days, submit to the department a correction of such information or data.

3. Timely filing of such report is a requirement of participation in the Medicaid pharmacy program. In the event that a pharmacy fails to file the required reports on or before the required due date, such pharmacy may be subject to removal as a provider from the fee-for-service pharmacy program.

§ 8. Paragraphs (a), (b) and (c) of subdivision 9 of section 367-a of the social services law, paragraphs (a) and (c) as amended by chapter 19 of the laws of 1998, paragraph (b) as amended by section 3 of part C of

chapter 58 of the laws of 2004, subparagraphs (i) and (ii) of paragraph (b) as amended by section 7 of part D of chapter 57 of the laws of 2017, and subparagraph (iii) of paragraph (b) as added by section 29 of part E of chapter 63 of the laws of 2005, are amended to read as follows:

(a) for drugs provided by medical practitioners and claimed separately by the practitioners[, the actual cost of the drugs to the practitioners; and] the lower of:

(i) (1) an amount equal to the national average drug acquisition cost set by the federal centers for medicare and medicaid services for the drug, if any, or if such amount is not available, the wholesale acquisition cost of the drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department, (2) the federal upper limit, if any, established by the federal centers for medicare and medicaid services; (3) the state maximum acquisition cost, if any, established pursuant to paragraph (e) of this subdivision; or (4) the actual cost of the drug to the practitioner.

(ii) Notwithstanding subparagraph (i) and paragraph (e) of this subdivision, if a drug has been purchased from a manufacturer by a covered entity pursuant to section 340B of the federal public health service act (42 USCA § 256b), the actual amount paid by such covered entity. For purposes of this subparagraph, a "covered entity" is an entity that meets the requirements of paragraph four of subsection (a) of such section, that elects to participate in the program established by such section, and that causes claims for payment for drugs covered by this subparagraph to be submitted to the medical assistance program, either directly or through an authorized contract pharmacy. No medical assistance payments may be made to a covered entity or to an authorized contract pharmacy of a covered entity for drugs that are eligible for

purchase under the section 340B program and are dispensed on an outpatient basis to patients of the covered entity, other than under the provisions of this subparagraph.

(b) for drugs dispensed by pharmacies:

(i) (A) if the drug dispensed is a generic prescription drug, the lower of: (1) an amount equal to the national average drug acquisition cost set by the federal centers for medicare and medicaid services for the drug, if any, or if such amount if not available, the wholesale acquisition cost of the drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department, less seventeen and one-half percent thereof; (2) the federal upper limit, if any, established by the federal centers for medicare and medicaid services; (3) the state maximum acquisition cost, if any, established pursuant to paragraph (e) of this subdivision; or (4) the dispensing pharmacy's usual and customary price charged to the general public; (B) if the drug dispensed is available without a prescription as required by section sixty-eight hundred ten of the education law but is reimbursed as an item of medical assistance pursuant to paragraph (a) of subdivision four of section three hundred sixty-five-a of this title, the lower of (1) an amount equal to the national average drug acquisition cost set by the federal centers for medicare and medicaid services for the drug, if any, or if such amount is not available, the wholesale acquisition cost of the drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department, (2) the federal upper limit, if any, established by the federal centers for medicare and medicaid services; (3) the state maximum acquisition cost if any, established pursuant to paragraph (e) of this subdi-

vision; or (4) the dispensing pharmacy's usual and customary price charged to the general public;

(ii) if the drug dispensed is a brand-name prescription drug, the lower of:

(A) an amount equal to the national average drug acquisition cost set by the federal centers for medicare and medicaid services for the drug, if any, or if such amount is not available, the wholesale acquisition cost of the drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department[, less three and three-tenths percent thereof]; or (B) the dispensing pharmacy's usual and customary price charged to the general public; and

(iii) notwithstanding subparagraphs (i) and (ii) of this paragraph and paragraphs (d) and (e) of this subdivision, if the drug dispensed is a drug that has been purchased from a manufacturer by a covered entity pursuant to section 340B of the federal public health service act (42 USCA § 256b), the actual amount paid by such covered entity pursuant to such section, plus the reasonable administrative costs, as determined by the commissioner, incurred by the covered entity or by an authorized contract pharmacy in connection with the purchase and dispensing of such drug and the tracking of such transactions. For purposes of this subparagraph, a "covered entity" is an entity that meets the requirements of paragraph four of subsection (a) of such section, that elects to participate in the program established by such section, and that causes claims for payment for drugs covered by this subparagraph to be submitted to the medical assistance program, either directly or through an authorized contract pharmacy. No medical assistance payments may be made to a covered entity or to an authorized contract pharmacy of a covered entity for drugs that are eligible for purchase under the section 340B program

and are dispensed on an outpatient basis to patients of the covered entity, other than under the provisions of this subparagraph. Pharmacies submitting claims for reimbursement of drugs purchased pursuant to section 340B of the public health service act shall notify the department that the claim is eligible for purchase under the 340B program, consistent with claiming instructions issued by the department to identify such claims.

(c) Notwithstanding subparagraph (i) of paragraph (b) of this subdivision, if a qualified prescriber certifies "brand medically necessary" or "brand necessary" in his or her own handwriting directly on the face of a prescription, or in the case of electronic prescriptions, inserts an electronic direction to clarify "brand medically necessary" or "brand necessary", for a multiple source drug for which a specific upper limit of reimbursement has been established by the federal agency, in addition to writing "d a w" in the box provided for such purpose on the prescription form, payment under this title for such drug must be made under the provisions of subparagraph (ii) of such paragraph.

§ 9. This act shall take effect October 1, 2024; provided that sections two and three of this act shall take effect January 1, 2025; and provided however, that the amendments to paragraph (e) of subdivision 7 of section 367-a of the social services law made by section five of this act shall not affect the repeal of such paragraph and shall be deemed repealed therewith provided, further, that the amendments to subdivision 9 of section 367-a of the social services law made by section eight of this act shall not affect the expiration of such subdivision pursuant to section 4 of chapter 19 of the laws of 1998, as amended, and shall expire therewith.

PART J

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

[BASIC HEALTH PROGRAM] ESSENTIAL PLAN

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) An initial determination of eligibility, including:

(A) eligibility to enroll in a qualified health plan;

(B) eligibility for Medicaid;

(C) eligibility for Child Health Plus;

(D) eligibility for the Basic Health Program;

(E) eligibility for the 1332 state innovation program;

(F) the amount of advance payments of the premium tax credit and level of cost-sharing reductions;

[(F)] (G) the amount of any other subsidy that may be available under law; and

[(G)] (H) eligibility for such other health insurance programs as determined by the commissioner; and

§ 8. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2024; provided, however, that sections four, five, six, and seven of this act shall take effect January 1, 2025; provided, further, that section six of this act shall only take effect upon the commissioner of health obtaining and maintaining all necessary approvals from the secretary of health and human services and the secretary of the treasury based on an amended application for a waiver for state innovation pursuant to section 1332 of the patient protection and affordable care act (P.L. 111-148) and subdivision 25 of section 268-c of the public health law; and provided, further, that the commissioner of health shall notify the legislative bill drafting commission upon the occurrence of the enactment of the legislation provided for in section six of this act in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of

effectuating the provisions of section 44 of the legislative law and section 70-b of the public officers law.

PART K

Section 1. Paragraph (a) of subdivision 1 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 1 of part F of chapter 57 of the laws of 2023, is amended and a new subdivision 9 is added to read as follows:

(a) The superintendent of financial services and the commissioner of health or their designee shall, from funds available in the hospital excess liability pool created pursuant to subdivision 5 of this section, purchase a policy or policies for excess insurance coverage, as authorized by paragraph 1 of subsection (e) of section 5502 of the insurance law; or from an insurer, other than an insurer described in section 5502 of the insurance law, duly authorized to write such coverage and actually writing medical malpractice insurance in this state; or shall purchase equivalent excess coverage in a form previously approved by the superintendent of financial services for purposes of providing equivalent excess coverage in accordance with section 19 of chapter 294 of the laws of 1985, for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June

30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, between July 1, 2018 and June 30, 2019, between July 1, 2019 and June 30, 2020, between July 1, 2020 and June 30, 2021, between July 1, 2021 and June 30, 2022, between July 1, 2022 and June 30, 2023, [and] between July 1, 2023 and June 30, 2024<u>, and between July 1, 2024 and June 30, 2025</u> or reimburse the hospital where the hospital purchases equivalent excess coverage as defined in subparagraph (i) of paragraph (a) of subdivision 1-a of this section for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002

and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, between July 1, 2018 and June 30, 2019, between July 1, 2019 and June 30, 2020, between July 1, 2020 and June 30, 2021, between July 1, 2021 and June 30, 2022, between July 1, 2022 and June 30, 2023, [and] between July 1, 2023 and June 30, 2024<u>, and between July 1, 2024 and June 30, 2025</u> for physicians or dentists certified as eligible for each such period or periods pursuant to subdivision 2 of this section by a general hospital licensed pursuant to article 28 of the public health law; provided that no single insurer shall write more than fifty percent of the total excess premium for a given policy year; and provided, however, that such eligible physicians or dentists must have in force an individual policy, from an insurer licensed in this state of primary malpractice insurance coverage in amounts of no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants under that policy during the period of such excess coverage for such occurrences or be endorsed as additional insureds under a hospital professional liability policy which is offered through a voluntary attending physician ("channeling") program previously permitted by the superintendent of financial services during the period of such excess coverage for such occurrences. During such period,

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

(9) This subdivision shall apply only to excess insurance coverage or equivalent excess coverage for physicians or dentists that is eligible

to be paid for from funds available in the hospital excess liability pool.

(a) Notwithstanding any law to the contrary, for any policy period beginning on or after July 1, 2023, excess coverage shall be purchased by a physician or dentist directly from a provider of excess insurance coverage or equivalent excess coverage. At the conclusion of the policy period the superintendent of financial services and the commissioner of health or their designee shall, from funds available in the hospital excess liability pool created pursuant to subdivision 5 of this section, pay fifty percent of the premium to the provider of excess insurance coverage or equivalent excess coverage, and the remaining fifty percent shall be paid one year thereafter.

(b) Notwithstanding any law to the contrary, for any policy period beginning on or after July 1, 2024, excess coverage shall be purchased by a physician or dentist directly from a provider of excess insurance coverage or equivalent excess coverage. Such provider of excess insurance coverage or equivalent excess coverage shall bill, in a manner consistent with paragraph (f) of this subdivision, the physician or dentist for an amount equal to fifty percent of the premium for such coverage, as established pursuant to paragraph (d) of this subdivision, during the policy period. At the conclusion of the policy period the superintendent of financial services and the commissioner of health or their designee shall, from funds available in the hospital excess liability pool created pursuant to subdivision 5 of this section, pay half of the remaining fifty percent of the premium to the provider of excess insurance coverage or equivalent excess coverage, and the remaining twenty-five percent shall be paid one year thereafter. If the funds available in the hospital excess liability pool are insufficient to meet

the percent of the costs of the excess coverage, the provisions of subdivision 8 of this section shall apply.

(c) If at the conclusion of the policy period, a physician or dentist, eligible for excess coverage paid for from funds available in the hospital excess liability pool, has failed to pay an amount equal to fifty percent of the premium as established pursuant to paragraph (d) of this subdivision, such excess coverage shall be cancelled and shall be null and void as of the first day on or after the commencement of a policy period where the liability for payment pursuant to this subdivision has not been met. The provider of excess coverage shall remit any portion of premium paid by the eligible physician or dentist for such a policy period.

(d) The superintendent of financial services shall establish a rate consistent with subdivision 3 of this section that providers of excess insurance coverage or equivalent excess coverage will charge for such coverage for each policy period. For the policy period beginning July 1, 2024, the superintendent of financial services may direct that the premium for that policy period be the same as it was for the policy period that concluded June 30, 2023.

(e) No provider of excess insurance coverage or equivalent excess coverage shall issue excess coverage to which this subdivision applies to any physician or dentist unless that physician or dentist meets the eligibility requirements for such coverage set forth in this section. The superintendent of financial services and the commissioner of health or their designee shall not make any payment under this subdivision to a provider of excess insurance coverage or equivalent excess coverage for excess coverage issued to a physician or dentist who does not meet the

eligibility requirements for participation in the hospital excess liability pool program set forth in this section.

(f) A provider of excess insurance coverage or equivalent coverage that issues excess coverage under this subdivision shall bill the physician or dentist for the portion of the premium required under paragraph (a) of this subdivision in twelve equal monthly installments or in such other manner as the physician or dentist may agree.

(g) The superintendent of financial services in consultation with the commissioner of health may promulgate regulations giving effect to the provisions of this subdivision.

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

(3)(a) The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006,

between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, between July 1, 2018 and June 30, 2019, between July 1, 2019 and June 30, 2020, between July 1, 2020 and June 30, 2021, between July 1, 2021 and June 30, 2022, between July 1, 2022 and June 30, 2023, [and] between July 1, 2023 and June 30, 2024, and between July 1, 2024 and June 30, 2025 allocable to each general hospital for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage by such general hospital in accordance with subdivision 2 of this section, and may amend such determination and certification as necessary.

(b) The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance or equivalent excess coverage for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003

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

January 1, 1994 to June 30, 1994, to the period July 1, 1994 to December 31, 1994, to the period January 1, 1995 to June 30, 1995, to the period July 1, 1995 to December 31, 1995, to the period January 1, 1996 to June 30, 1996, to the period July 1, 1996 to December 31, 1996, to the period January 1, 1997 to June 30, 1997, to the period July 1, 1997 to December 31, 1997, to the period January 1, 1998 to June 30, 1998, to the period July 1, 1998 to December 31, 1998, to the period January 1, 1999 to June 30, 1999, to the period July 1, 1999 to December 31, 1999, to the period January 1, 2000 to June 30, 2000, to the period July 1, 2000 to December 31, 2000, to the period January 1, 2001 to June 30, 2001, to the period July 1, 2001 to June 30, 2002, to the period July 1, 2002 to June 30, 2003, to the period July 1, 2003 to June 30, 2004, to the period July 1, 2004 to June 30, 2005, to the period July 1, 2005 and June 30, 2006, to the period July 1, 2006 and June 30, 2007, to the period July 1, 2007 and June 30, 2008, to the period July 1, 2008 and June 30, 2009, to the period July 1, 2009 and June 30, 2010, to the period July 1, 2010 and June 30, 2011, to the period July 1, 2011 and June 30, 2012, to the period July 1, 2012 and June 30, 2013, to the period July 1, 2013 and June 30, 2014, to the period July 1, 2014 and June 30, 2015, to the period July 1, 2015 and June 30, 2016, to the period July 1, 2016 and June 30, 2017, to the period July 1, 2017 to June 30, 2018, to the period July 1, 2018 to June 30, 2019, to the period July 1, 2019 to June 30, 2020, to the period July 1, 2020 to June 30, 2021, to the period July 1, 2021 to June 30, 2022, to the period July 1, 2022 to June 30, 2023, [and] to the period July 1, 2023 to June 30, 2024, and to the period July 1, 2024 to June 30, 2025.

§ 3. Paragraphs (a), (b), (c), (d) and (e) of subdivision 8 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law

and rules and other laws relating to malpractice and professional medical conduct, as amended by section 3 of part F of chapter 57 of the laws of 2023, are amended to read as follows:

(a) To the extent funds available to the hospital excess liability pool pursuant to subdivision 5 of this section as amended, and pursuant to section 6 of part J of chapter 63 of the laws of 2001, as may from time to time be amended, which amended this subdivision, are insufficient to meet the costs of excess insurance coverage or equivalent excess coverage for coverage periods during the period July 1, 1992 to June 30, 1993, during the period July 1, 1993 to June 30, 1994, during the period July 1, 1994 to June 30, 1995, during the period July 1, 1995 to June 30, 1996, during the period July 1, 1996 to June 30, 1997, during the period July 1, 1997 to June 30, 1998, during the period July 1, 1998 to June 30, 1999, during the period July 1, 1999 to June 30, 2000, during the period July 1, 2000 to June 30, 2001, during the period July 1, 2001 to October 29, 2001, during the period April 1, 2002 to June 30, 2002, during the period July 1, 2002 to June 30, 2003, during the period July 1, 2003 to June 30, 2004, during the period July 1, 2004 to June 30, 2005, during the period July 1, 2005 to June 30, 2006, during the period July 1, 2006 to June 30, 2007, during the period July 1, 2007 to June 30, 2008, during the period July 1, 2008 to June 30, 2009, during the period July 1, 2009 to June 30, 2010, during the period July 1, 2010 to June 30, 2011, during the period July 1, 2011 to June 30, 2012, during the period July 1, 2012 to June 30, 2013, during the period July 1, 2013 to June 30, 2014, during the period July 1, 2014 to June 30, 2015, during the period July 1, 2015 to June 30, 2016, during the period July 1, 2016 to June 30, 2017, during the period July 1, 2017 to June 30, 2018, during the period July 1, 2018 to June 30, 2019,

during the period July 1, 2019 to June 30, 2020, during the period July 1, 2020 to June 30, 2021, during the period July 1, 2021 to June 30, 2022, during the period July 1, 2022 to June 30, 2023, [and] during the period July 1, 2023 to June 30, 2024, and during the period July 1, 2024 to June 30, 2025 allocated or reallocated in accordance with paragraph (a) of subdivision 4-a of this section to rates of payment applicable to state governmental agencies, each physician or dentist for whom a policy for excess insurance coverage or equivalent excess coverage is purchased for such period shall be responsible for payment to the provider of excess insurance coverage or equivalent excess coverage of an allocable share of such insufficiency, based on the ratio of the total cost of such coverage for such physician to the sum of the total cost of such coverage for all physicians applied to such insufficiency.

(b) Each provider of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the peri-

od July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to June 30, 2020, or covering the period July 1, 2020 to June 30, 2021, or covering the period July 1, 2021 to June 30, 2022, or covering the period July 1, 2022 to June 30, 2023, or covering the period July 1, 2023 to June 30, 2024, or covering the period July 1, 2024 to June 30, 2025 shall notify a covered physician or dentist by mail, mailed to the address shown on the last application for excess insurance coverage or equivalent excess coverage, of the amount due to such provider from such physician or dentist for such coverage period determined in accordance with paragraph (a) of this subdivision. Such amount shall be due from such physician or dentist to such provider of excess insurance coverage or equivalent excess coverage in a time and manner determined by the superintendent of financial services.

(c) If a physician or dentist liable for payment of a portion of the costs of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or

covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to June 30, 2020, or covering the period July 1, 2020 to June 30, 2021, or covering the period July 1, 2021 to June 30, 2022, or covering the period July 1, 2022 to June 30, 2023, or covering the period July 1, 2023 to June 30, 2024<u>, or covering the period July 1, 2024 to June 30, 2025</u> determined in accordance with paragraph (a) of this subdivision fails, refuses or neglects to make payment to the provider of excess insurance coverage or equivalent excess coverage in such time and manner as determined by the superintendent of financial services pursuant to paragraph (b) of this subdivision, excess insurance coverage or equivalent excess coverage purchased for such physician or dentist in accordance with this section for such coverage period shall be cancelled and shall be null and void as of the

first day on or after the commencement of a policy period where the liability for payment pursuant to this subdivision has not been met.

(d) Each provider of excess insurance coverage or equivalent excess coverage shall notify the superintendent of financial services and the commissioner of health or their designee of each physician and dentist eligible for purchase of a policy for excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to

June 30, 2020, or covering the period July 1, 2020 to June 30, 2021, or covering the period July 1, 2021 to June 30, 2022, or covering the period July 1, 2022 to June 30, 2023, or covering the period July 1, 2023 to June 30, 2024, or covering the period July 1, 2024 to June 30, 2025 that has made payment to such provider of excess insurance coverage or equivalent excess coverage in accordance with paragraph (b) of this subdivision and of each physician and dentist who has failed, refused or neglected to make such payment.

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

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

June 30, 2018, and covering the period July 1, 2018 to June 30, 2019, and covering the period July 1, 2019 to June 30, 2020, and covering the period July 1, 2020 to June 30, 2021, and covering the period July 1, 2021 to June 30, 2022, and covering the period July 1, 2022 to June 30, 2023 for, and covering the period July 1, 2023 to June 30, 2024, and covering the period July 1, 2024 to June 30, 2025 a physician or dentist where such excess insurance coverage or equivalent excess coverage is cancelled in accordance with paragraph (c) of this subdivision.

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

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

2025, at which time and thereafter such surcharge shall not exceed twenty-five percent of the approved adequate rate, and that such annual surcharges shall continue for such period of time as shall be sufficient to satisfy such deficiency. The superintendent shall not impose such surcharge during the period commencing July 1, 2009 and ending June 30, 2010. On and after July 1, 1989, the surcharge prescribed by this section shall be retained by insurers to the extent that they insured physicians and surgeons during the July 1, 1985 through June 30, [2024] 2025 policy periods; in the event and to the extent physicians and surgeons were insured by another insurer during such periods, all or a pro rata share of the surcharge, as the case may be, shall be remitted to such other insurer in accordance with rules and regulations to be promulgated by the superintendent. Surcharges collected from physicians and surgeons who were not insured during such policy periods shall be apportioned among all insurers in proportion to the premium written by each insurer during such policy periods; if a physician or surgeon was insured by an insurer subject to rates established by the superintendent during such policy periods, and at any time thereafter a hospital, health maintenance organization, employer or institution is responsible for responding in damages for liability arising out of such physician's or surgeon's practice of medicine, such responsible entity shall also remit to such prior insurer the equivalent amount that would then be collected as a surcharge if the physician or surgeon had continued to remain insured by such prior insurer. In the event any insurer that provided coverage during such policy periods is in liquidation, the property/casualty insurance security fund shall receive the portion of surcharges to which the insurer in liquidation would have been entitled. The surcharges authorized herein shall be deemed to be income earned for

the purposes of section 2303 of the insurance law. The superintendent, in establishing adequate rates and in determining any projected deficiency pursuant to the requirements of this section and the insurance law, shall give substantial weight, determined in his discretion and judgment, to the prospective anticipated effect of any regulations promulgated and laws enacted and the public benefit of stabilizing malpractice rates and minimizing rate level fluctuation during the period of time necessary for the development of more reliable statistical experience as to the efficacy of such laws and regulations affecting medical, dental or podiatric malpractice enacted or promulgated in 1985, 1986, by this act and at any other time. Notwithstanding any provision of the insurance law, rates already established and to be established by the superintendent pursuant to this section are deemed adequate if such rates would be adequate when taken together with the maximum authorized annual surcharges to be imposed for a reasonable period of time whether or not any such annual surcharge has been actually imposed as of the establishment of such rates.

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

§ 5. The superintendent of financial services and the commissioner of health shall determine, no later than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15, 2013, June 15, 2014, June 15, 2015, June 15, 2016, June 15, 2017, June

15, 2018, June 15, 2019, June 15, 2020, June 15, 2021, June 15, 2022, June 15, 2023, [and] June 15, 2024, and June 15, 2025 the amount of funds available in the hospital excess liability pool, created pursuant to section 18 of chapter 266 of the laws of 1986, and whether such funds are sufficient for purposes of purchasing excess insurance coverage for eligible participating physicians and dentists during the period July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30, 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30, 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30, 2018, or July 1, 2018 to June 30, 2019, or July 1, 2019 to June 30, 2020, or July 1, 2020 to June 30, 2021, or July 1, 2021 to June 30, 2022, or July 1, 2022 to June 30, 2023, or July 1, 2023 to June 30, 2024, or July 1, 2024 to June 30, 2025 as applicable.

(a) This section shall be effective only upon a determination, pursuant to section five of this act, by the superintendent of financial services and the commissioner of health, and a certification of such determination to the state director of the budget, the chair of the senate committee on finance and the chair of the assembly committee on ways and means, that the amount of funds in the hospital excess liability pool, created pursuant to section 18 of chapter 266 of the laws of 1986, is insufficient for purposes of purchasing excess insurance coverage for eligible participating physicians and dentists during the period July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July

1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30, 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30, 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30, 2018, or July 1, 2018 to June 30, 2019, or July 1, 2019 to June 30, 2020, or July 1, 2020 to June 30, 2021, or July 1, 2021 to June 30, 2022, or July 1, 2022 to June 30, 2023, or July 1, 2023 to June 30, 2024 , or July 1, 2024 to June 30, 2025 as applicable.

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

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

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

dentists who have applied for excess coverage or equivalent excess coverage for the coverage period beginning the first of July, two thousand [twenty-three] twenty-four.

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

PART L

Section 1. Subdivision 9 of section 2803 of the public health law is REPEALED.

§ 2. Section 461-s of the social services law is REPEALED.

§ 3. Subdivision 1, paragraph (f) of subdivision 3, paragraphs (a) and (d) of subdivision 5 and subdivisions 5-a and 12 of section 2807-m of the public health law, subdivision 1, paragraph (f) of subdivision 3, paragraph (a) of subdivision 5 and subdivision 12 as amended and paragraph (d) of subdivision 5 as added by section 6 of part Y of chapter 56 of the laws of 2020 and subdivision 5-a as amended by section 6 of part C of chapter 57 of the laws of 2023, are amended to read as follows:

1. Definitions. For purposes of this section, the following definitions shall apply, unless the context clearly requires otherwise:

(a) ["Clinical research" means patient-oriented research, epidemiologic and behavioral studies, or outcomes research and health services research that is approved by an institutional review board by the time the clinical research position is filled.

(b) "Clinical research plan" means a plan submitted by a consortium or teaching general hospital for a clinical research position which demonstrates, in a form to be provided by the commissioner, the following:

(i) financial support for overhead, supervision, equipment and other resources equal to the amount of funding provided pursuant to subparagraph (i) of paragraph (b) of subdivision five-a of this section by the teaching general hospital or consortium for the clinical research position;

(ii) experience the sponsor-mentor and teaching general hospital has in clinical research and the medical field of the study;

(iii) methods, data collection and anticipated measurable outcomes of the clinical research to be performed;

(iv) training goals, objectives and experience the researcher will be provided to assess a future career in clinical research;

(v) scientific relevance, merit and health implications of the research to be performed;

(vi) information on potential scientific meetings and peer review journals where research results can be disseminated;

(vii) clear and comprehensive details on the clinical research position;

(viii) qualifications necessary for the clinical research position and strategy for recruitment;

(ix) non-duplication with other clinical research positions from the same teaching general hospital or consortium;

(x) methods to track the career of the clinical researcher once the term of the position is complete; and

(xi) any other information required by the commissioner to implement subparagraph (i) of paragraph (b) of subdivision five-a of this section.

(xii) The clinical review plan submitted in accordance with this paragraph may be reviewed by the commissioner in consultation with experts outside the department of health.

(c) "Clinical research position" means a post-graduate residency position which:

(i) shall not be required in order for the researcher to complete a graduate medical education program;

(ii) may be reimbursed by other sources but only for costs in excess of the funding distributed in accordance with subparagraph (i) of paragraph (b) of subdivision five-a of this section;

(iii) shall exceed the minimum standards that are required by the residency review committee in the specialty the researcher has trained or is currently training;

(iv) shall not be previously funded by the teaching general hospital or supported by another funding source at the teaching general hospital in the past three years from the date the clinical research plan is submitted to the commissioner;

(v) may supplement an existing research project;

(vi) shall be equivalent to a full-time position comprising of no less than thirty-five hours per week for one or two years;

(vii) shall provide, or be filled by a researcher who has formalized instruction in clinical research, including biostatistics, clinical trial design, grant writing and research ethics;

(viii) shall be supervised by a sponsor-mentor who shall either (A) be employed, contracted for employment or paid through an affiliated faculty practice plan by a teaching general hospital which has received at least one research grant from the National Institutes of Health in the past five years from the date the clinical research plan is submitted to the commissioner; (B) maintain a faculty appointment at a medical, dental or podiatric school located in New York state that has received at least one research grant from the National Institutes of Health in

the past five years from the date the clinical research plan is submitted to the commissioner; or (C) be collaborating in the clinical research plan with a researcher from another institution that has received at least one research grant from the National Institutes of Health in the past five years from the date the clinical research plan is submitted to the commissioner; and

(ix) shall be filled by a researcher who is (A) enrolled or has completed a graduate medical education program, as defined in paragraph (i) of this subdivision; (B) a United States citizen, national, or permanent resident of the United States; and (C) a graduate of a medical, dental or podiatric school located in New York state, a graduate or resident in a graduate medical education program, as defined in paragraph (i) of this subdivision, where the sponsoring institution, as defined in paragraph (q) of this subdivision, is located in New York state, or resides in New York state at the time the clinical research plan is submitted to the commissioner.

(d)] "Consortium" means an organization or association, approved by the commissioner in consultation with the council, of general hospitals which provide graduate medical education, together with any affiliated site; provided that such organization or association may also include other providers of health care services, medical schools, payors or consumers, and which meet other criteria pursuant to subdivision six of this section.

[(e)] (b) "Council" means the New York state council on graduate medical education.

[(f)] (c) "Direct medical education" means the direct costs of residents, interns and supervising physicians.

[(g)] (d) "Distribution period" means each calendar year set forth in subdivision two of this section.

[(h)] (e) "Faculty" means persons who are employed by or under contract for employment with a teaching general hospital or are paid through a teaching general hospital's affiliated faculty practice plan and maintain a faculty appointment at a medical school. Such persons shall not be limited to persons with a degree in medicine.

[(i)] (f) "Graduate medical education program" means a post-graduate medical education residency in the United States which has received accreditation from a nationally recognized accreditation body or has been approved by a nationally recognized organization for medical, osteopathic, podiatric or dental residency programs including, but not limited to, specialty boards.

[(j)] (g) "Indirect medical education" means the estimate of costs, other than direct costs, of educational activities in teaching hospitals as determined in accordance with the methodology applicable for purposes of determining an estimate of indirect medical education costs for reimbursement for inpatient hospital service pursuant to title XVIII of the federal social security act (medicare).

[(k)] (h) "Medicare" means the methodology used for purposes of reimbursing inpatient hospital services provided to beneficiaries of title XVIII of the federal social security act.

[(l)] (i) "Primary care" residents specialties shall include family medicine, general pediatrics, primary care internal medicine, and primary care obstetrics and gynecology. In determining whether a residency is in primary care, the commissioner shall consult with the council.

[(m)] (j) "Regions", for purposes of this section, shall mean the regions as defined in paragraph (b) of subdivision sixteen of section

twenty-eight hundred seven-c of this article as in effect on June thirtieth, nineteen hundred ninety-six. For purposes of distributions pursuant to subdivision five-a of this section, except distributions made in accordance with paragraph (a) of subdivision five-a of this section, "regions" shall be defined as New York city and the rest of the state.

[(n)] (k) "Regional pool" means a professional education pool established on a regional basis by the commissioner from funds available pursuant to sections twenty-eight hundred seven-s and twenty-eight hundred seven-t of this article.

[(o)] (l) "Resident" means a person in a graduate medical education program which has received accreditation from a nationally recognized accreditation body or in a program approved by any other nationally recognized organization for medical, osteopathic or dental residency programs including, but not limited to, specialty boards.

[(p) "Shortage specialty" means a specialty determined by the commissioner, in consultation with the council, to be in short supply in the state of New York.

(q)] (m) "Sponsoring institution" means the entity that has the overall responsibility for a program of graduate medical education. Such institutions shall include teaching general hospitals, medical schools, consortia and diagnostic and treatment centers.

[(r)] (n) "Weighted resident count" means a teaching general hospital's total number of residents as of July first, nineteen hundred ninety-five, including residents in affiliated non-hospital ambulatory settings, reported to the commissioner. Such resident counts shall reflect the weights established in accordance with rules and regulations adopted by the state hospital review and planning council and approved by the commissioner for purposes of implementing subdivision twenty-five

of section twenty-eight hundred seven-c of this article and in effect on July first, nineteen hundred ninety-five. Such weights shall not be applied to specialty hospitals, specified by the commissioner, whose primary care mission is to engage in research, training and clinical care in specialty eye and ear, special surgery, orthopedic, joint disease, cancer, chronic care or rehabilitative services.

[(s)] (o) "Adjustment amount" means an amount determined for each teaching hospital for periods prior to January first, two thousand nine by:

(i) determining the difference between (A) a calculation of what each teaching general hospital would have been paid if payments made pursuant to paragraph (a-3) of subdivision one of section twenty-eight hundred seven-c of this article between January first, nineteen hundred ninety-six and December thirty-first, two thousand three were based solely on the case mix of persons eligible for medical assistance under the medical assistance program pursuant to title eleven of article five of the social services law who are enrolled in health maintenance organizations and persons paid for under the family health plus program enrolled in approved organizations pursuant to title eleven-D of article five of the social services law during those years, and (B) the actual payments to each such hospital pursuant to paragraph (a-3) of subdivision one of section twenty-eight hundred seven-c of this article between January first, nineteen hundred ninety-six and December thirty-first, two thousand three.

(ii) reducing proportionally each of the amounts determined in subparagraph (i) of this paragraph so that the sum of all such amounts totals no more than one hundred million dollars;

(iii) further reducing each of the amounts determined in subparagraph (ii) of this paragraph by the amount received by each hospital as a distribution from funds designated in paragraph (a) of subdivision five of this section attributable to the period January first, two thousand three through December thirty-first, two thousand three, except that if such amount was provided to a consortium then the amount of the reduction for each hospital in the consortium shall be determined by applying the proportion of each hospital's amount determined under subparagraph (i) of this paragraph to the total of such amounts of all hospitals in such consortium to the consortium award;

(iv) further reducing each of the amounts determined in subparagraph (iii) of this paragraph by the amounts specified in paragraph [(t)] (p) of this subdivision; and

(v) dividing each of the amounts determined in subparagraph (iii) of this paragraph by seven.

[(t)] (p) "Extra reduction amount" shall mean an amount determined for a teaching hospital for which an adjustment amount is calculated pursuant to paragraph [(s)] (o) of this subdivision that is the hospital's proportionate share of the sum of the amounts specified in paragraph [(u)] (q) of this subdivision determined based upon a comparison of the hospital's remaining liability calculated pursuant to paragraph [(s)] (o) of this subdivision to the sum of all such hospital's remaining liabilities.

[(u)] (q) "Allotment amount" shall mean an amount determined for teaching hospitals as follows:

(i) for a hospital for which an adjustment amount pursuant to paragraph [(s)] (o) of this subdivision does not apply, the amount received by the hospital pursuant to paragraph (a) of subdivision five of this

section attributable to the period January first, two thousand three through December thirty-first, two thousand three, or

(ii) for a hospital for which an adjustment amount pursuant to paragraph [(s)] (o) of this subdivision applies and which received a distribution pursuant to paragraph (a) of subdivision five of this section attributable to the period January first, two thousand three through December thirty-first, two thousand three that is greater than the hospital's adjustment amount, the difference between the distribution amount and the adjustment amount.

(f) Effective January first, two thousand five through December thirty-first, two thousand eight, each teaching general hospital shall receive a distribution from the applicable regional pool based on its distribution amount determined under paragraphs (c), (d) and (e) of this subdivision and reduced by its adjustment amount calculated pursuant to paragraph [(s)] (o) of subdivision one of this section and, for distributions for the period January first, two thousand five through December thirty-first, two thousand five, further reduced by its extra reduction amount calculated pursuant to paragraph [(t)] (p) of subdivision one of this section.

(a) Up to thirty-one million dollars annually for the periods January first, two thousand through December thirty-first, two thousand three, and up to twenty-five million dollars plus the sum of the amounts specified in paragraph [(n)] (k) of subdivision one of this section for the period January first, two thousand five through December thirty-first, two thousand five, and up to thirty-one million dollars annually for the period January first, two thousand six through December thirty-first, two thousand seven, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this

section for supplemental distributions in each such region to be made by the commissioner to consortia and teaching general hospitals in accordance with a distribution methodology developed in consultation with the council and specified in rules and regulations adopted by the commissioner.

(d) Notwithstanding any other provision of law or regulation, for the period January first, two thousand five through December thirty-first, two thousand five, the commissioner shall distribute as supplemental payments the allotment specified in paragraph [(n)] (k) of subdivision one of this section.

5-a. Graduate medical education innovations pool. (a) Supplemental distributions. (i) Thirty-one million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for distributions pursuant to subdivision five of this section and in accordance with section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York as in effect on January first, two thousand eight[; provided, however, for purposes of funding the empire clinical research investigation program (ECRIP) in accordance with paragraph eight of subdivision (e) and paragraph two of subdivision (f) of section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York, distributions shall be made using two regions defined as New York city and the rest of the state and the dollar amount set forth in subparagraph (i) of paragraph two of subdivision (f) of section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York shall be increased from sixty thousand dollars to seventy-five thousand dollars].

(ii) For periods on and after January first, two thousand nine, supplemental distributions pursuant to subdivision five of this section and in accordance with section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York shall no longer be made and the provisions of section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York shall be null and void.

(b) [Empire clinical research investigator program (ECRIP). Nine million one hundred twenty thousand dollars annually for the period January first, two thousand nine through December thirty-first, two thousand ten, and two million two hundred eighty thousand dollars for the period January first, two thousand eleven, through March thirty-first, two thousand eleven, nine million one hundred twenty thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to eight million six hundred twelve thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to eight million six hundred twelve thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, up to eight million six hundred twelve thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, and up to eight million six hundred twelve thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section to be allocated regionally with two-thirds of the available funding going to New York city and one-third of the available funding

going to the rest of the state and shall be available for distribution as follows:

Distributions shall first be made to consortia and teaching general hospitals for the empire clinical research investigator program (ECRIP) to help secure federal funding for biomedical research, train clinical researchers, recruit national leaders as faculty to act as mentors, and train residents and fellows in biomedical research skills based on hospital-specific data submitted to the commissioner by consortia and teaching general hospitals in accordance with clause (G) of this subparagraph. Such distributions shall be made in accordance with the following methodology:

(A) The greatest number of clinical research positions for which a consortium or teaching general hospital may be funded pursuant to this subparagraph shall be one percent of the total number of residents training at the consortium or teaching general hospital on July first, two thousand eight for the period January first, two thousand nine through December thirty-first, two thousand nine rounded up to the nearest one position.

(B) Distributions made to a consortium or teaching general hospital shall equal the product of the total number of clinical research positions submitted by a consortium or teaching general hospital and accepted by the commissioner as meeting the criteria set forth in paragraph (b) of subdivision one of this section, subject to the reduction calculation set forth in clause (C) of this subparagraph, times one hundred ten thousand dollars.

(C) If the dollar amount for the total number of clinical research positions in the region calculated pursuant to clause (B) of this subparagraph exceeds the total amount appropriated for purposes of this

paragraph, including clinical research positions that continue from and were funded in prior distribution periods, the commissioner shall eliminate one-half of the clinical research positions submitted by each consortium or teaching general hospital rounded down to the nearest one position. Such reduction shall be repeated until the dollar amount for the total number of clinical research positions in the region does not exceed the total amount appropriated for purposes of this paragraph. If the repeated reduction of the total number of clinical research positions in the region by one-half does not render a total funding amount that is equal to or less than the total amount reserved for that region within the appropriation, the funding for each clinical research position in that region shall be reduced proportionally in one thousand dollar increments until the total dollar amount for the total number of clinical research positions in that region does not exceed the total amount reserved for that region within the appropriation. Any reduction in funding will be effective for the duration of the award. No clinical research positions that continue from and were funded in prior distribution periods shall be eliminated or reduced by such methodology.

(D) Each consortium or teaching general hospital shall receive its annual distribution amount in accordance with the following:

(I) Each consortium or teaching general hospital with a one-year ECRIP award shall receive its annual distribution amount in full upon completion of the requirements set forth in items (I) and (II) of clause (G) of this subparagraph. The requirements set forth in items (IV) and (V) of clause (G) of this subparagraph must be completed by the consortium or teaching general hospital in order for the consortium or teaching general hospital to be eligible to apply for ECRIP funding in any subsequent funding cycle.

(II) Each consortium or teaching general hospital with a two-year ECRIP award shall receive its first annual distribution amount in full upon completion of the requirements set forth in items (I) and (II) of clause (G) of this subparagraph. Each consortium or teaching general hospital will receive its second annual distribution amount in full upon completion of the requirements set forth in item (III) of clause (G) of this subparagraph. The requirements set forth in items (IV) and (V) of clause (G) of this subparagraph must be completed by the consortium or teaching general hospital in order for the consortium or teaching general hospital to be eligible to apply for ECRIP funding in any subsequent funding cycle.

(E) Each consortium or teaching general hospital receiving distributions pursuant to this subparagraph shall reserve seventy-five thousand dollars to primarily fund salary and fringe benefits of the clinical research position with the remainder going to fund the development of faculty who are involved in biomedical research, training and clinical care.

(F) Undistributed or returned funds available to fund clinical research positions pursuant to this paragraph for a distribution period shall be available to fund clinical research positions in a subsequent distribution period.

(G) In order to be eligible for distributions pursuant to this subparagraph, each consortium and teaching general hospital shall provide to the commissioner by July first of each distribution period, the following data and information on a hospital-specific basis. Such data and information shall be certified as to accuracy and completeness by the chief executive officer, chief financial officer or chair of the consortium governing body of each consortium or teaching general hospital and

shall be maintained by each consortium and teaching general hospital for five years from the date of submission:

(I) For each clinical research position, information on the type, scope, training objectives, institutional support, clinical research experience of the sponsor-mentor, plans for submitting research outcomes to peer reviewed journals and at scientific meetings, including a meeting sponsored by the department, the name of a principal contact person responsible for tracking the career development of researchers placed in clinical research positions, as defined in paragraph (c) of subdivision one of this section, and who is authorized to certify to the commissioner that all the requirements of the clinical research training objectives set forth in this subparagraph shall be met. Such certification shall be provided by July first of each distribution period;

(II) For each clinical research position, information on the name, citizenship status, medical education and training, and medical license number of the researcher, if applicable, shall be provided by December thirty-first of the calendar year following the distribution period;

(III) Information on the status of the clinical research plan, accomplishments, changes in research activities, progress, and performance of the researcher shall be provided upon completion of one-half of the award term;

(IV) A final report detailing training experiences, accomplishments, activities and performance of the clinical researcher, and data, methods, results and analyses of the clinical research plan shall be provided three months after the clinical research position ends; and

(V) Tracking information concerning past researchers, including but not limited to (A) background information, (B) employment history, (C) research status, (D) current research activities, (E) publications and

presentations, (F) research support, and (G) any other information necessary to track the researcher; and

(VI) Any other data or information required by the commissioner to implement this subparagraph.

(H) Notwithstanding any inconsistent provision of this subdivision, for periods on and after April first, two thousand thirteen, ECRIP grant awards shall be made in accordance with rules and regulations promulgated by the commissioner. Such regulations shall, at a minimum:

(1) provide that ECRIP grant awards shall be made with the objective of securing federal funding for biomedical research, training clinical researchers, recruiting national leaders as faculty to act as mentors, and training residents and fellows in biomedical research skills;

(2) provide that ECRIP grant applicants may include interdisciplinary research teams comprised of teaching general hospitals acting in collaboration with entities including but not limited to medical centers, hospitals, universities and local health departments;

(3) provide that applications for ECRIP grant awards shall be based on such information requested by the commissioner, which shall include but not be limited to hospital-specific data;

(4) establish the qualifications for investigators and other staff required for grant projects eligible for ECRIP grant awards; and

(5) establish a methodology for the distribution of funds under ECRIP grant awards.

(c)] Physician loan repayment program. One million nine hundred sixty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, one million nine hundred sixty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, one million

nine hundred sixty thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, four hundred ninety thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, one million seven hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to one million seven hundred five thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to one million seven hundred five thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, up to one million seven hundred five thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, and up to one million seven hundred five thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for purposes of physician loan repayment in accordance with subdivision ten of this section. Notwithstanding any contrary provision of this section, sections one hundred twelve and one hundred sixty-three of the state finance law, or any other contrary provision of law, such funding shall be allocated regionally with one-third of available funds going to New York city and two-thirds of available funds going to the rest of the state and shall be distributed in a manner to be determined by the commissioner without a competitive bid or request for proposal process as follows:

(i) Funding shall first be awarded to repay loans of up to twenty-five physicians who train in primary care or specialty tracks in teaching general hospitals, and who enter and remain in primary care or specialty practices in underserved communities, as determined by the commissioner.

(ii) After distributions in accordance with subparagraph (i) of this paragraph, all remaining funds shall be awarded to repay loans of physicians who enter and remain in primary care or specialty practices in underserved communities, as determined by the commissioner, including but not limited to physicians working in general hospitals, or other health care facilities.

(iii) In no case shall less than fifty percent of the funds available pursuant to this paragraph be distributed in accordance with subparagraphs (i) and (ii) of this paragraph to physicians identified by general hospitals.

(iv) In addition to the funds allocated under this paragraph, for the period April first, two thousand fifteen through March thirty-first, two thousand sixteen, two million dollars shall be available for the purposes described in subdivision ten of this section;

(v) In addition to the funds allocated under this paragraph, for the period April first, two thousand sixteen through March thirty-first, two thousand seventeen, two million dollars shall be available for the purposes described in subdivision ten of this section;

(vi) Notwithstanding any provision of law to the contrary, and subject to the extension of the Health Care Reform Act of 1996, sufficient funds shall be available for the purposes described in subdivision ten of this section in amounts necessary to fund the remaining year commitments for awards made pursuant to subparagraphs (iv) and (v) of this paragraph.

[(d)] (c) Physician practice support. Four million nine hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, four million nine hundred thousand dollars annually for the period January first, two thousand nine through December thirty-first, two thousand ten, one million two hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, four million three hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to four million three hundred sixty thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to four million three hundred sixty thousand dollars for each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, up to four million three hundred sixty thousand dollars for each fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, and up to four million three hundred sixty thousand dollars for each fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for purposes of physician practice support. Notwithstanding any contrary provision of this section, sections one hundred twelve and one hundred sixty-three of the state finance law, or any other contrary provision of law, such funding shall be allocated regionally with one-third of available funds going to New York city and two-thirds of available funds going to the rest of the state and shall be distributed in a manner to

be determined by the commissioner without a competitive bid or request for proposal process as follows:

(i) Preference in funding shall first be accorded to teaching general hospitals for up to twenty-five awards, to support costs incurred by physicians trained in primary or specialty tracks who thereafter establish or join practices in underserved communities, as determined by the commissioner.

(ii) After distributions in accordance with subparagraph (i) of this paragraph, all remaining funds shall be awarded to physicians to support the cost of establishing or joining practices in underserved communities, as determined by the commissioner, and to hospitals and other health care providers to recruit new physicians to provide services in underserved communities, as determined by the commissioner.

(iii) In no case shall less than fifty percent of the funds available pursuant to this paragraph be distributed to general hospitals in accordance with subparagraphs (i) and (ii) of this paragraph.

[(e)] (d) Work group. For funding available pursuant to paragraphs (b) and (c)[, (d) and (e)] of this subdivision:

(i) The department shall appoint a work group from recommendations made by associations representing physicians, general hospitals and other health care facilities to develop a streamlined application process by June first, two thousand twelve.

(ii) Subject to available funding, applications shall be accepted on a continuous basis. The department shall provide technical assistance to applicants to facilitate their completion of applications. An applicant shall be notified in writing by the department within ten days of receipt of an application as to whether the application is complete and if the application is incomplete, what information is outstanding. The

department shall act on an application within thirty days of receipt of a complete application.

[(f)] (e) Study on physician workforce. Five hundred ninety thousand dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, one hundred forty-eight thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, five hundred sixteen thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to four hundred eighty-seven thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to four hundred eighty-seven thousand dollars for each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, up to four hundred eighty-seven thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, and up to four hundred eighty-seven thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available to fund a study of physician workforce needs and solutions including, but not limited to, an analysis of residency programs and projected physician workforce and community needs. The commissioner shall enter into agreements with one or more organizations to conduct such study based on a request for proposal process.

[(g)] (f) Diversity in medicine/post-baccalaureate program. Notwithstanding any inconsistent provision of section one hundred twelve or one

hundred sixty-three of the state finance law or any other law, one million nine hundred sixty thousand dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, four hundred ninety thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, one million seven hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to one million six hundred five thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to one million six hundred five thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, up to one million six hundred five thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, and up to one million six hundred five thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for distributions to the Associated Medical Schools of New York to fund its diversity program including existing and new post-baccalaureate programs for minority and economically disadvantaged students and encourage participation from all medical schools in New York. The associated medical schools of New York shall report to the commissioner on an annual basis regarding the use of funds for such purpose in such form and manner as specified by the commissioner.

[(h)] (g) In the event there are undistributed funds within amounts made available for distributions pursuant to this subdivision, such funds may be reallocated and distributed in current or subsequent distribution periods in a manner determined by the commissioner for any purpose set forth in this subdivision.

12. Notwithstanding any provision of law to the contrary, applications submitted on or after April first, two thousand sixteen, for the physician loan repayment program pursuant to paragraph [(c)] (b) of subdivision five-a of this section and subdivision ten of this section or the physician practice support program pursuant to paragraph [(d)] (c) of subdivision five-a of this section, shall be subject to the following changes:

(a) Awards shall be made from the total funding available for new awards under the physician loan repayment program and the physician practice support program, with neither program limited to a specific funding amount within such total funding available;

(b) An applicant may apply for an award for either physician loan repayment or physician practice support, but not both;

(c) An applicant shall agree to practice for three years in an underserved area and each award shall provide up to forty thousand dollars for each of the three years; and

(d) To the extent practicable, awards shall be timed to be of use for job offers made to applicants.

§ 4. Subparagraph (xvi) of paragraph (a) of subdivision 7 of section 2807-s of the public health law, as amended by section 8 of part Y of chapter 56 of the laws of 2020, is amended to read as follows:

(xvi) provided further, however, for periods prior to July first, two thousand nine, amounts set forth in this paragraph shall be reduced by

an amount equal to the actual distribution reductions for all facilities pursuant to paragraph [(s)] (o) of subdivision one of section twenty-eight hundred seven-m of this article.

§ 5. Subdivision (c) of section 92-dd of the state finance law, as amended by section 9 of part Y of chapter 56 of the laws of 2020, is amended to read as follows:

(c) The pool administrator shall, from appropriated funds transferred to the pool administrator from the comptroller, continue to make payments as required pursuant to sections twenty-eight hundred seven-k, twenty-eight hundred seven-m (not including payments made pursuant to subdivision five-b and paragraphs (b), (c)[, (d),, (f)] and [(g)] (f) of subdivision five-a of section twenty-eight hundred seven-m), and twenty-eight hundred seven-w of the public health law, paragraph (e) of subdivision twenty-five of section twenty-eight hundred seven-c of the public health law, paragraphs (b) and (c) of subdivision thirty of section twenty-eight hundred seven-c of the public health law, paragraph (b) of subdivision eighteen of section twenty-eight hundred eight of the public health law, subdivision seven of section twenty-five hundred-d of the public health law and section eighty-eight of chapter one of the laws of nineteen hundred ninety-nine.

§ 6. Paragraph (c) of subdivision 1 of section 461-b of the social services law is REPEALED.

§ 7. Article 27-H of the public health law is REPEALED.

§ 8. Paragraph (c) of subdivision 11 of section 230 of the public health law, as amended by chapter 343 of the laws of 1980, subparagraph (ii) as amended by section 10 of part B of chapter 57 of the laws of 2023, is amended to read as follows:

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

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

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

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

§ 9. Paragraph (g) of subdivision 11 of section 230 of the public health law is REPEALED and paragraph (h) is relettered paragraph (g).

§ 10. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2024; provided, however, the amendments to subparagraph (xvi) of paragraph (a) of subdivision 7 of section 2807-s of the public health law made by section four of this act shall not affect the expiration of such section and shall be deemed to expire therewith.

PART M

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

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

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

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

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

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

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

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

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

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

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

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

PART N

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

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

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

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

3. Any person, including a minor, who is pregnant may give effective consent for any and all medical, dental, health and hospital services

relating to [prenatal] reproductive health care, including consent to terminate a pregnancy for any reason.

§ 3. The opening paragraph of section 2599-aa of the public health law, as added by chapter 1 of the laws of 2019, is amended to read as follows:

The legislature finds that comprehensive reproductive health care is a fundamental component of every individual's health, privacy and equality, including minors. Therefore, it is the policy of the state that:

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

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

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

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

PART O

Section 1. Subdivision 1 of section 2807-k of the public health law is amended by adding a new paragraph (h) to read as follows:

(h) "Underinsured" shall mean an individual with out of pocket medical costs that amount to more than ten percent of such individual's gross annual income for the past twelve months.

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

9-a. (a) As a condition for participation in pool distributions authorized pursuant to this section and section twenty-eight hundred seven-w of this article for periods on and after January first, two thousand nine, general hospitals shall, effective for periods on and after January first, two thousand seven, establish financial aid policies and procedures, in accordance with the provisions of this subdivision, for reducing charges otherwise applicable to low-income individuals without health insurance or underinsured individuals, or who have exhausted their health insurance benefits, and who can demonstrate an inability to pay full charges, and also, at the hospital's discretion, for reducing or discounting the collection of co-pays and deductible payments from those individuals who can demonstrate an inability to pay such amounts.

(b) Such reductions from charges for [uninsured] patients with incomes below at least [three] four hundred percent of the federal poverty level shall result in a charge to such individuals that does not exceed [the greater of] the amount that would have been paid for the same services [by the "highest volume payor" for such general hospital as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare), or for services] provided pursuant to title XIX of the federal social security

act (medicaid), and provided further that such amounts shall be adjusted according to income level as follows:

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

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

(iii) For patients with incomes between at least [one] three hundred [fifty-one] one percent and [two] four hundred [fifty] percent of the federal poverty level, the hospital shall collect no more than the amount identified after application of a proportional sliding fee sched-

ule under which patients with lower income shall pay the lowest amounts. Such schedule shall provide that the amount the hospital may collect for such patients increases from the [twenty] ten percent figure described in subparagraph (ii) of this paragraph in equal increments as the income of the patient increases, up to a maximum of [the greater] twenty percent of the amount that would have been paid for the same services [by the "highest volume payor" for such general hospital, as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare) or for services] provided pursuant to title XIX of the federal social security act (medicaid), or for underinsured patients, up to a maximum of twenty percent of the amount that would have been paid pursuant to such patient's insurance cost sharing; [and

(iv) For patients with incomes between at least two hundred fifty-one percent and three hundred percent of the federal poverty level, the hospital shall collect no more than the greater of the amount that would have been paid for the same services by the "highest volume payor" for such general hospital as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare), or for services provided pursuant to title XIX of the federal social security act (medicaid).

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

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

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

(c) Such policies and procedures shall be clear, understandable, in writing and publicly available in summary form and each general hospital participating in the pool shall ensure that every patient is made aware of the existence of such policies and procedures and is provided, in a timely manner, with a summary of such policies and procedures [upon request]. Any summary provided to patients shall, at a minimum, include specific information as to income levels used to determine eligibility for assistance, a description of the primary service area of the hospital and the means of applying for assistance. For general hospitals with twenty-four hour emergency departments, such policies and procedures shall require the written notification of patients during the intake and registration process, and during discharge of the patient, and through the conspicuous posting of language-appropriate information in the general hospital, and information on bills and statements sent to patients, that financial aid may be available to qualified patients and how to obtain further information. For specialty hospitals without twenty-four hour emergency departments, such notification shall take place through written materials provided to patients during the intake and registration process prior to the provision of any health care services or procedures, and during discharge of the patient, and through information on bills and statements sent to patients, that financial aid may be available to qualified patients and how to obtain further information. Application materials shall include a notice to patients that upon submission of a completed application, including any information or documentation needed to determine the patient's eligibility pursuant to the hospital's financial assistance policy, the patient may disregard any bills until the hospital has rendered a decision on the application in accordance with this paragraph.

(d) Such policies and procedures shall include clear, objective criteria for determining a patient's ability to pay and for providing such adjustments to payment requirements as are necessary. In addition to adjustment mechanisms such as sliding fee schedules and discounts to fixed standards, such policies and procedures shall also provide for the use of installment plans for the payment of outstanding balances by patients pursuant to the provisions of the hospital's financial assistance policy. The monthly payment under such a plan shall not exceed [ten] five percent of the gross monthly income of the patient[, provided, however, that if patient assets are considered under such a policy, then patient assets which are not excluded assets pursuant to subparagraph (vi) of paragraph (b) of this subdivision may be considered in addition to the limit on monthly payments]. The rate of interest charged to the patient on the unpaid balance, if any, shall not exceed [the rate for a ninety-day security issued by the United States Department of Treasury, plus .5] two percent and no plan shall include an accelerator or similar clause under which a higher rate of interest is triggered upon a missed payment. If such policies and procedures include a requirement of a deposit prior to non-emergent, medically-necessary care, such deposit must be included as part of any financial aid consideration. Such policies and procedures shall be applied consistently to all eligible patients.

(e) Such policies and procedures shall permit patients to apply for assistance [within at least ninety days of the date of discharge or date of service and provide at least twenty days for patients to submit a completed application] at any time during the collection process. Such policies and procedures may require that patients seeking payment adjustments provide appropriate financial information and documentation

in support of their application, provided, however, that such application process shall not be unduly burdensome or complex. General hospitals shall, upon request, assist patients in understanding the hospital's policies and procedures and in applying for payment adjustments. Application forms shall be printed in the "primary languages" of patients served by the general hospital. For the purposes of this paragraph, "primary languages" shall include any language that is either (i) used to communicate, during at least five percent of patient visits in a year, by patients who cannot speak, read, write or understand the English language at the level of proficiency necessary for effective communication with health care providers, or (ii) spoken by non-English speaking individuals comprising more than one percent of the primary hospital service area population, as calculated using demographic information available from the United States Bureau of the Census, supplemented by data from school systems. Decisions regarding such applications shall be made within thirty days of receipt of a completed application. Such policies and procedures shall require that the hospital issue any denial/approval of such application in writing with information on how to appeal the denial and shall require the hospital to establish an appeals process under which it will evaluate the denial of an application. Nothing in this subdivision shall be interpreted as prohibiting a hospital from making the availability of financial assistance contingent upon the patient first applying for coverage under title XIX of the social security act (medicaid) or another insurance program if, in the judgment of the hospital, the patient may be eligible for medicaid or another insurance program, and upon the patient's cooperation in following the hospital's financial assistance application requirements, including the provision of information needed to make a

determination on the patient's application in accordance with the hospital's financial assistance policy.

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

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

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

(iii) require the hospital to notify the commissioner upon making any change to its primary service area, and to include a description of its

primary service area in the hospital's annual implementation report filed pursuant to subdivision three of section twenty-eight hundred three-l of this article.

(g) Nothing in this subdivision shall be interpreted as precluding hospitals from extending payment adjustments for medically necessary non-emergency hospital services to patients outside of the hospital's primary service area. For patients determined to be eligible for financial aid under the terms of a hospital's financial aid policy, such policies and procedures shall prohibit any limitations on financial aid for services based on the medical condition of the applicant, other than typical limitations or exclusions based on medical necessity or the clinical or therapeutic benefit of a procedure or treatment.

(h) Such policies and procedures shall prohibit the denial of admission or denial of treatment for services that are reasonably anticipated to be medically necessary because the patient has an unpaid medical bill. Such policies and procedures shall [not permit] prohibit the forced sale or foreclosure of a patient's primary residence in order to collect an outstanding medical bill and shall require the hospital to refrain from sending an account to collection if the patient has submitted a completed application for financial aid, including any required supporting documentation, while the hospital determines the patient's eligibility for such aid. Such policies and procedures shall prohibit the sale of medical debt accumulated pursuant to this section to a third party, unless the third party explicitly purchases such medical debt in order to relieve the debt of the patient. Such policies and procedures shall provide for written notification, which shall include notification on a patient bill, to a patient not less than thirty days prior to the referral of debts for collection and shall require that the collection

agency obtain the hospital's written consent prior to commencing a legal action. Such policies and procedures shall prohibit a hospital from commencing a legal action related to the recovery of medical debt or unpaid bills against patients with incomes below four hundred percent of the federal poverty level. In any legal action related to the recovery of medical debt or unpaid bills by or on behalf of a hospital, the complaint shall be accompanied by an affidavit by the hospital's chief financial officer stating that based upon the hospital's reasonable effort to determine the patient's income, the patient whom they are taking legal action against does not have an income below four hundred percent of the federal poverty level. Such policies and procedures shall require all general hospital staff who interact with patients or have responsibility for billing and collections to be trained in such policies and procedures, and require the implementation of a mechanism for the general hospital to measure its compliance with such policies and procedures. Such policies and procedures shall require that any collection agency under contract with a general hospital for the collection of debts follow the hospital's financial assistance policy, including providing information to patients on how to apply for financial assistance where appropriate. Such policies and procedures shall prohibit collections from a patient who is determined to be eligible for medical assistance pursuant to title XIX of the federal social security act at the time services were rendered and for which services medicaid payment is available.

(i) Reports required to be submitted to the department by each general hospital as a condition for participation in the pools, and which contain, in accordance with applicable regulations, a certification from an independent certified public accountant or independent licensed

public accountant or an attestation from a senior official of the hospital that the hospital is in compliance with conditions of participation in the pools, shall also contain, for reporting periods on and after January first, two thousand seven:

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

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

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

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

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

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

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

(viii) the number of liens placed on the primary residences of patients through the collection process used by a hospital].

(j) Within ninety days of the effective date of this subdivision each hospital shall submit to the commissioner a written report on its policies and procedures for financial assistance to patients which are used by the hospital on the effective date of this subdivision. Such report shall include copies of its policies and procedures, including material which is distributed to patients, and a description of the hospital's financial aid policies and procedures. Such description shall include the income levels of patients on which eligibility is based, the financial aid eligible patients receive and the means of calculating such aid, and the service area, if any, used by the hospital to determine eligibility.

(k) In the event it is determined by the commissioner that the state will be unable to secure all necessary federal approvals to include, as part of the state's approved state plan under title nineteen of the federal social security act, a requirement, as set forth in paragraph [one] (a) of this subdivision, that compliance with this subdivision is a condition of participation in pool distributions authorized pursuant to this section and section twenty-eight hundred seven-w of this article, then such condition of participation shall be deemed null and void and, notwithstanding section twelve of this chapter, failure to comply with the provisions of this subdivision by a hospital on and after the date of such determination shall make such hospital liable for a civil penalty not to exceed ten thousand dollars for each such violation. The

imposition of such civil penalties shall be subject to the provisions of section twelve-a of this chapter.

(l) A hospital or its collection agent shall not commence a civil action against a patient or delegate a collection activity to a debt collector for nonpayment for at least one hundred eighty days after the first post-service bill is issued and until a hospital has made reasonable efforts to determine whether a patient qualifies for financial assistance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART P

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

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

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

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

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

PART Q

Section 1. Section 6542 of the education law, as amended by chapter 48 of the laws of 2012, subdivisions 3 and 5 as amended by section 1 of part T of chapter 57 of the laws of 2013, is amended to read as follows:

§ 6542. Performance of medical services. 1. Notwithstanding any other provision of law, a physician assistant may perform medical services, but only when under the supervision of a physician and only when such acts and duties as are assigned to him or her are within the scope of practice of such supervising physician <u>unless otherwise permitted by this section</u>.

<u>1-a. (a) A physician assistant may practice without the supervision of a physician under the following circumstances:</u>

(i) Where the physician assistant, licensed under section sixty-five hundred forty-one of this article has practiced for more than eight thousand hours; and

(A) is practicing in primary care. For purposes of this clause, "primary care" shall mean non-surgical care in the fields of general pediatrics, general adult medicine, general geriatric medicine, general internal medicine, obstetrics and gynecology, family medicine, or such other related areas as determined by the commissioner of health; or

(B) is employed by a health system or hospital established under article twenty-eight of the public health law, and the health system or hospital determines the physician assistant meets the qualifications of the medical staff bylaws and the health system or hospital gives the physician assistant privileges; and

(ii) Where a physician assistant licensed under section sixty-five hundred forty-one of this article has completed a program approved by the department of health, in consultation with the department, when such services are performed within the scope of such program.

(b) The department and the department of health are authorized to promulgate and update regulations pursuant to this section.

2. [Supervision] Where supervision is required by this section, it shall be continuous but shall not be construed as necessarily requiring the physical presence of the supervising physician at the time and place where such services are performed.

3. [No physician shall employ or supervise more than four physician assistants in his or her private practice.

4.] Nothing in this article shall prohibit a hospital from employing physician assistants provided they [work under the supervision of a physician designated by the hospital and not beyond the scope of prac-

tice of such physician. The numerical limitation of subdivision three of this section shall not apply to services performed in a hospital.

5. Notwithstanding any other provision of this article, nothing shall prohibit a physician employed by or rendering services to the department of corrections and community supervision under contract from supervising no more than six physician assistants in his or her practice for the department of corrections and community supervision.

6. Notwithstanding any other provision of law, a trainee in an approved program may perform medical services when such services are performed within the scope of such program.] meet the qualifications of the medical staff bylaws and are given privileges and otherwise meet the requirements of this section.

4. A physician assistant shall be authorized to prescribe, dispense, order, administer, or procure items necessary to commence or complete a course of therapy.

5. A physician assistant may prescribe and order a patient specific order or non-patient specific regimen to a licensed pharmacist or registered professional nurse, pursuant to regulations promulgated by the commissioner of health, and consistent with the public health law, for administering immunizations. Nothing in this subdivision shall authorize unlicensed persons to administer immunizations, vaccines or other drugs.

[7] 6. Nothing in this article, or in article thirty-seven of the public health law, shall be construed to authorize physician assistants to perform those specific functions and duties specifically delegated by law to those persons licensed as allied health professionals under the public health law or this chapter.

§ 2. Subdivision 1 of section 3701 of the public health law, as amended by chapter 48 of the laws of 2012, is amended to read as follows:

1. to promulgate regulations defining and restricting the duties [which may be assigned to] of physician assistants [by their supervising physician, the degree of supervision required and the manner in which such duties may be performed] consistent with section sixty-five hundred forty-two of the education law.;

§ 3. Section 3702 of the public health law, as amended by chapter 48 of the laws of 2012, is amended to read as follows:

§ 3702. Special provisions. 1. Inpatient medical orders. A licensed physician assistant employed or extended privileges by a hospital may, if permissible under the bylaws, rules and regulations of the hospital, write medical orders, including those for controlled substances and durable medical equipment, for inpatients [under the care of the physician responsible for his or her supervision. Countersignature of such orders may be required if deemed necessary and appropriate by the supervising physician or the hospital, but in no event shall countersignature be required prior to execution].

2. Withdrawing blood. A licensed physician assistant or certified nurse practitioner acting within his or her lawful scope of practice may supervise and direct the withdrawal of blood for the purpose of determining the alcoholic or drug content therein under subparagraph one of paragraph (a) of subdivision four of section eleven hundred ninety-four of the vehicle and traffic law, notwithstanding any provision to the contrary in clause (ii) of such subparagraph.

3. Prescriptions for controlled substances. A licensed physician assistant, in good faith and acting within his or her lawful scope of

practice, and to the extent assigned by his or her supervising physician as applicable by section sixty-five hundred forty-two of the education law, may prescribe controlled substances as a practitioner under article thirty-three of this chapter, to patients under the care of such physician responsible for his or her supervision. The commissioner, in consultation with the commissioner of education, may promulgate such regulations as are necessary to carry out the purposes of this section.

§ 4. Section 3703 of the public health law, as amended by chapter 48 of the laws of 2012, is amended to read as follows:

§ 3703. Statutory construction. A physician assistant may perform any function in conjunction with a medical service lawfully performed by the physician assistant, in any health care setting, that a statute authorizes or directs a physician to perform and that is appropriate to the education, training and experience of the licensed physician assistant and within the ordinary practice of the supervising physician, as applicable pursuant to section sixty-five hundred forty-two of the education law. This section shall not be construed to increase or decrease the lawful scope of practice of a physician assistant under the education law.

§ 5. Paragraph a of subdivision 2 of section 902 of the education law, as amended by chapter 376 of the laws of 2015, is amended to read as follows:

a. The board of education, and the trustee or board of trustees of each school district, shall employ, at a compensation to be agreed upon by the parties, a qualified physician, a physician assistant, or a nurse practitioner to the extent authorized by the nurse practice act and consistent with subdivision three of section six thousand nine hundred two of this chapter, to perform the duties of the director of school

health services, including any duties conferred on the school physician or school medical inspector under any provision of law, to perform and coordinate the provision of health services in the public schools and to provide health appraisals of students attending the public schools in the city or district. The physicians, physicians assistants or nurse practitioners so employed shall be duly licensed pursuant to applicable law.

§ 6. Subdivision 5 of section 6810 of the education law, as added by chapter 881 of the laws of 1972, is amended to read as follows:

5. Records of all prescriptions filled or refilled shall be maintained for a period of at least five years and upon request made available for inspection and copying by a representative of the department. Such records shall indicate date of filling or refilling, [doctor's] prescriber's name, patient's name and address and the name or initials of the pharmacist who prepared, compounded, or dispensed the prescription. Records of prescriptions for controlled substances shall be maintained pursuant to requirements of article thirty-three of the public health law.

§ 7. Subdivision 27 of section 3302 of the public health law, as amended by chapter 92 of the laws of 2021, is amended to read as follows:

27. "Practitioner" means:

A physician, physician assistant, dentist, podiatrist, veterinarian, scientific investigator, or other person licensed, or otherwise permitted to dispense, administer or conduct research with respect to a controlled substance in the course of a licensed professional practice or research licensed pursuant to this article. Such person shall be deemed a "practitioner" only as to such substances, or conduct relating

to such substances, as is permitted by [his] their license, permit or otherwise permitted by law.

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

3. This article shall not be construed as prohibiting medication related tasks provided by a certified medication aide working in a residential health care facility, as defined in section twenty-eight hundred one of the public health law, in accordance with regulations developed by the commissioner, in consultation with the commissioner of health. The commissioner, in consultation with the commissioner of health, shall adopt regulations governing certified medication aides that, at a minimum, shall:

a. specify the medication-related tasks that may be performed by certified medication aides pursuant to this subdivision. Such tasks shall include the administration of medications which are routine and pre-filled or otherwise packaged in a manner that promotes relative ease of administration, provided that administration of medications by injection, sterile procedures, and central line maintenance shall be prohibited. Provided, however, such prohibition shall not apply to injections of insulin or other injections for diabetes care, to injections of low molecular weight heparin, and to pre-filled auto-injections of naloxone and epinephrine for emergency purposes, and provided, further, that entities employing certified medication aides pursuant to this subdivision shall establish a systematic approach to address drug diversion;

b. provide that medication-related tasks performed by certified medication aides may be performed only under the supervision of a registered professional nurse licensed in New York state, as set forth in this

subdivision and subdivision twelve of section sixty-nine hundred nine of this article;

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

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

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

(iii) authorizing multiple registered professional nurses to jointly agree to assign medication-related tasks to a certified medication aide, provided further that only one registered professional nurse shall be required to determine if the certified medication aide has demonstrated competency in the medication-related task to be performed;

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

e. provide that only a certified nurse aide may perform medication-related tasks as a certified medication aide when such aide has:

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

(ii) a high school diploma, or its equivalent;

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

(iv) at least one year of experience providing nurse aide services in a residential health care facility licensed pursuant to article twenty-eight of the public health law or a similarly licensed facility in another state or United States territory;

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

(vi) completed the requisite training and demonstrated competencies of a certified medication aide as determined by the commissioner of health in consultation with the commissioner;

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

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

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

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

h. provide that a certified medication aide shall not be authorized to perform any medication-related tasks or activities pursuant to this subdivision that are outside the scope of practice of a licensed practical nurse or any medication-related tasks that have not been appropriately assigned by the supervising registered professional nurse;

i. provide that a certified medication aide shall document all medication-related tasks provided to an individual, including medication administration to each individual through the use of a medication administration record; and

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

§ 9. Section 6909 of the education law is amended by adding two new subdivisions 12 and 13 to read as follows:

12. A registered professional nurse, while working for a residential health care facility licensed pursuant to article twenty-eight of the public health law, may, in accordance with this subdivision, assign certified medication aides to perform medication-related tasks for individuals pursuant to the provisions of subdivision three of section sixty-nine hundred eight of this article and supervise certified medication aides who perform assigned medication-related tasks.

13. Notwithstanding subdivision seven of section sixty-five hundred nine of this title, a certified nurse practitioner may directly assign and supervise a medical assistant in an outpatient setting the task of drawing and administering immunizations to patients, provided such medical assistant receives appropriate training from the certified nurse practitioner and the certified nurse practitioner remains responsible for the actions of the medical assistant.

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

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

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

12. Notwithstanding subdivision eleven of section sixty-five hundred thirty of this title, a licensed physician may directly assign and supervise a medical assistant in an outpatient setting the task of drawing and administering immunizations to patients, provided such medical assistant receives appropriate training from the licensed physician and the licensed physician remains responsible for the actions of the medical assistant.

§ 12. Section 6545 of the education law, as amended by chapter 48 of the laws of 2012, is amended to read as follows:

§ 6545. [Emergency services rendered by physician assistant] Special provisions. 1. Notwithstanding any inconsistent provision of any general, special or local law, any physician assistant properly licensed in this state who voluntarily and without the expectation of monetary compensation renders first aid or emergency treatment at the scene of an accident or other emergency, outside a hospital, doctor's office or any other place having proper and necessary medical equipment, to a person who is unconscious, ill or injured, shall not be liable for damages for injuries alleged to have been sustained by such person or for damages for the death of such person alleged to have occurred by reason of an act or omission in the rendering of such first aid or emergency treatment unless it is established that such injuries were or such death was caused by gross negligence on the part of such physician assistant. Nothing in this section shall be deemed or construed to relieve a licensed physician assistant from liability for damages for injuries or death caused by an act or omission on the part of a physician assistant while rendering professional services in the normal and ordinary course of his or her practice.

2. Notwithstanding subdivision eleven of section sixty-five hundred thirty of this title, a licensed physician assistant authorized pursuant to section sixty-five hundred forty-two of this article to practice without supervision of a physician, may directly assign and supervise a medical assistant in an outpatient setting the task of drawing and administering immunizations to patients, provided such medical assistant receives appropriate training from the licensed physician assistant and the licensed physician assistant remains responsible for the actions of the medical assistant.

§ 13. Section 6601 of the education law, as amended by chapter 576 of the laws of 2001, is amended to read as follows:

§ 6601. Definition of practice of dentistry. The practice of the profession of dentistry is defined as diagnosing, treating, operating, or prescribing for any disease, pain, injury, deformity, or physical condition of the oral and maxillofacial area related to restoring and maintaining dental health. The practice of dentistry includes the prescribing and fabrication of dental prostheses and appliances. The practice of dentistry may include performing physical evaluations in conjunction with the provision of dental treatment, including the administration of vaccinations against influenza, SARS-CoV-2, Human papillomavirus (HPV), and vaccinations related to a declared public health emergency. The practice of dentistry may also include offering of HIV, hepatitis C, and hemoglobin A1C screening or diagnostic tests.

§ 14. Section 6605-b of the education law, as added by chapter 437 of the laws of 2001 and subdivision 1 as amended by chapter 198 of the laws of 2022, is amended to read as follows:

§ 6605-b. Dental hygiene restricted local infiltration and block anesthesia/nitrous oxide analgesia certificate. 1. A dental hygienist

shall not administer or monitor nitrous oxide analgesia or local infiltration or block anesthesia in the practice of dental hygiene without a dental hygiene restricted local infiltration and block anesthesia/nitrous oxide analgesia certificate and except under the personal supervision of a dentist and in accordance with regulations promulgated by the commissioner. Personal supervision, for purposes of this section, means that the supervising dentist remains in the dental office where the local infiltration or block anesthesia or nitrous oxide analgesia services are being performed, personally authorizes and prescribes the use of local infiltration or block anesthesia or nitrous oxide analgesia for the patient and, before dismissal of the patient, personally examines the condition of the patient after the use of local infiltration or block anesthesia or nitrous oxide analgesia is completed. It is professional misconduct for a dentist to fail to provide the supervision required by this section, and any dentist found guilty of such misconduct under the procedures prescribed in section sixty-five hundred ten of this title shall be subject to the penalties prescribed in section sixty-five hundred eleven of this title.

2. The commissioner shall promulgate regulations establishing standards and procedures for the issuance of such certificate. Such standards shall require completion of an educational program and/or course of training or experience sufficient to ensure that a dental hygienist is specifically trained in the administration and monitoring of nitrous oxide analgesia and local infiltration or block anesthesia, the possible effects of such use, and in the recognition of and response to possible emergency situations.

3. The fee for a dental hygiene restricted local infiltration and block anesthesia/nitrous oxide analgesia certificate shall be twenty-

five dollars and shall be paid on a triennial basis upon renewal of such certificate. A certificate may be suspended or revoked in the same manner as a license to practice dental hygiene.

§ 15. Subdivision 1 of section 6606 of the education law, as amended by chapter 239 of the laws of 2013, is amended to read as follows:

1. The practice of the profession of dental hygiene is defined as the performance of dental services which shall include removing calcareous deposits, accretions and stains from the exposed surfaces of the teeth which begin at the epithelial attachment and applying topical agents indicated for a complete dental prophylaxis, removing cement, placing or removing rubber dam, removing sutures, placing matrix band, providing patient education, applying topical medication, placing pre-fit orthodontic bands, using light-cure composite material, taking cephalometric radiographs, taking two-dimensional and three-dimensional photography of dentition, adjusting removable appliances including nightguards, bleaching trays, retainers and dentures, placing and exposing diagnostic dental X-ray films, performing topical fluoride applications and topical anesthetic applications, polishing teeth, taking medical history, charting caries, taking impressions for study casts, placing and removing temporary restorations, administering and monitoring nitrous oxide analgesia and administering and monitoring local infiltration and block anesthesia, subject to certification in accordance with section sixty-six hundred five-b of this article, and any other function in the definition of the practice of dentistry as may be delegated by a licensed dentist in accordance with regulations promulgated by the commissioner. The practice of dental hygiene may be conducted in the office of any licensed dentist or in any appropriately equipped school or public institution but must be done either under the supervision of a licensed

dentist or, in the case of a registered dental hygienist working for a hospital as defined in article twenty-eight of the public health law[,] or pursuant to a collaborative arrangement with a licensed and registered dentist [who has a formal relationship with the same hospital] pursuant to section sixty-six hundred seven-a of this article and in accordance with regulations promulgated by the department in consultation with the department of health. [Such collaborative arrangement shall not obviate or supersede any law or regulation which requires identified services to be performed under the personal supervision of a dentist. When dental hygiene services are provided pursuant to a collaborative agreement, such dental hygienist shall instruct individuals to visit a licensed dentist for comprehensive examination or treatment.]

§ 16. The education law is amended by adding a new section 6607-a to read as follows:

§ 6607-a. Practice of collaborative practice dental hygiene and use of title "registered dental hygienist, collaborative practice" (RDH-CP). 1. The practice of the profession of dental hygiene, as defined under this article, may be performed in collaboration with a licensed dentist provided such services are performed in accordance with a written practice agreement and written practice protocols to be known as a collaborative practice agreement. Under a collaborative practice agreement, dental hygienists may perform all services which are designated in regulation without prior evaluation of a dentist or medical professional and may be performed without supervision in a collaborative practice setting.

2. (a) The collaborative practice agreement shall include consideration for medically compromised patients, specific medical conditions, and age-and procedure-specific practice protocols, including, but not

limited to recommended intervals for the performance of dental hygiene services and a periodicity in which an examination by a dentist should occur.

(b) The collaborative agreement shall be:

(i) signed and maintained by the dentist, the dental hygienist, and the facility, program, or organization;

(ii) reviewed annually by the collaborating dentist and dental hygienist; and

(iii) made available to the department and other interested parties upon request.

(c) Only one agreement between a collaborating dentist and registered dental hygienist, collaborative practice (RDH-CP) may be in force at a time.

3. Before performing any services authorized under this section, a dental hygienist shall provide the patient with a written statement advising the patient that the dental hygiene services provided are not a substitute for a dental examination by a licensed dentist and instructing individuals to visit a licensed dentist for comprehensive examination or treatment. If the dental hygienist makes any referrals to the patient for further dental procedures, the dental hygienist must fill out a referral form and provide a copy of the form to the collaborating dentist.

4. The collaborative practice dental hygienist may enter into a contractual arrangement with any New York state licensed and registered dentist, health care facility, program, and/or non-profit organization to perform dental hygiene services in the following settings: dental offices; long-term care facilities/skilled nursing facilities; public or private schools; public health agencies/federally qualified health

centers; correctional facilities; public institutions/mental health facilities; drug treatment facilities; and domestic violence shelters.

5. A collaborating dentist shall have collaborative agreements with no more than six collaborative practice dental hygienists. The department may grant exceptions to these limitations for public health settings on a case-by-case basis.

6. A dental hygienist must make application to the department to practice as a registered dental hygienist, collaborative practice (RDH-CP) and pay a fee set by the department. As a condition of collaborative practice, the dental hygienist shall have been engaged in practice for at least three years with a minimum of four thousand five hundred practice hours and shall complete an eight hour continuing education program that includes instruction in medical emergency procedures, risk management, dental hygiene jurisprudence and professional ethics.

§ 17. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2024; provided, however, that sections one through seven of this act shall take effect one year after this act shall have become a law.

PART R

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

ARTICLE 169

INTERSTATE MEDICAL LICENSURE COMPACT

Section 8860. Short title.

8861. Purpose.

8862. Definitions.

§ 8860. Short title. This article shall be known and may be cited as the "interstate medical licensure compact".

§ 8861. Purpose. In order to strengthen access to health care, and in recognition of the advances in the delivery of health care, the member states of the interstate medical licensure compact have allied in common purpose to develop a comprehensive process that complements the existing

licensing and regulatory authority of state medical boards, provides a streamlined process that allows physicians to become licensed in multiple states, thereby enhancing the portability of a medical license and ensuring the safety of patients. The compact creates another pathway for licensure and does not otherwise change a state's existing medical practice act. The compact also adopts the prevailing standard for licensure and affirms that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter, and therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located. State medical boards that participate in the compact retain the jurisdiction to impose an adverse action against a license to practice medicine in that state issued to a physician through the procedures in the compact.

§ 8862. Definitions. In this compact:

1. "Bylaws" means those bylaws established by the interstate commission pursuant to section eighty-eight hundred seventy-one of this article for its governance, or for directing and controlling its actions and conduct.

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

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

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

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

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

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

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

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

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

11. "Physician" means any person who:

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

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

examinations accepted by a state medical board as an equivalent examination for licensure purposes;

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

(d) Holds specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association's Bureau of Osteopathic Specialists;

(e) Possesses a full and unrestricted license to engage in the practice of medicine issued by a member board;

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

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

(h) Has never had a controlled substance license or permit suspended or revoked by a state or the United States drug enforcement administration; and

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

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

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

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

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

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

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

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

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

(a) the state of principal residence for the physician, or

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

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

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

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

3. The interstate commission is authorized to develop rules to facilitate redesignation of another member state as the state of principal license.

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

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

(a) Static qualifications, which include verification of medical education, graduate medical education, results of any medical or licensing examination, and other qualifications as determined by the interstate commission through rule, shall not be subject to additional primary source verification where already primary source verified by the state of principal license.

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

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

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

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

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

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

6. An expedited license obtained though the compact shall be terminated if a physician fails to maintain a license in the state of principal licensure for a non-disciplinary reason, without redesignation of a new state of principal licensure.

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

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

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

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

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

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

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

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

2. Physicians shall comply with all continuing professional development or continuing medical education requirements for renewal of a license issued by a member state.

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

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

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

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

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

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

3. Member boards shall report disciplinary or investigatory information determined as necessary and proper by rule of the interstate commission.

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

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

6. All information provided to the interstate commission or distributed by member boards shall be confidential, filed under seal, and used only for investigatory or disciplinary matters.

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

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

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

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

4. Member boards may share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the compact.

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

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

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

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

(a) impose the same or lesser sanction or sanctions against the physician so long as such sanctions are consistent with the medical practice act of that state; or

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

4. If a license granted to a physician by a member board is revoked, surrendered, or relinquished in lieu of discipline, or suspended, then any license or licenses issued to the physician by any other member board or boards shall be suspended, automatically and immediately without further action necessary by the other member board or boards, for ninety days upon entry of the order by the disciplining board, to permit the member board or boards to investigate the basis for the action under the medical practice act of that state. A member board may terminate the automatic suspension of the license it issued prior to the completion of the ninety day suspension period in a manner consistent with the medical practice act of that state.

§ 8871. Interstate medical licensure compact commission. 1. The member states hereby create the "interstate medical licensure compact commission".

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

3. The interstate commission shall be a body corporate and joint agency of the member states and shall have all the responsibilities, powers,

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

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

(a) Allopathic or osteopathic physician appointed to a member board;

(b) Executive director, executive secretary, or similar executive of a member board; or

(c) Member of the public appointed to a member board.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11. The interstate commission shall establish an executive committee, which shall include officers, members, and others as determined by the bylaws. The executive committee shall have the power to act on behalf of the interstate commission, with the exception of rulemaking, during periods when the interstate commission is not in session. When acting on behalf of the interstate commission, the executive committee shall oversee the administration of the compact including enforcement and compliance with the provisions of the compact, its bylaws and rules, and other such duties as necessary.

12. The interstate commission shall establish other committees for governance and administration of the compact.

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

1. Oversee and maintain the administration of the compact;

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

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

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

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

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

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

7. Establish and maintain one or more offices;

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

9. Purchase and maintain insurance and bonds;

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

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

12. Accept donations and grants of money, equipment, supplies, materials and services, and to receive, utilize, and dispose of it in a manner consistent with the conflict of interest policies established by the interstate commission;

13. Lease, purchase, accept contributions or donations of, or otherwise to own, hold, improve, or use, any property, real, personal, or mixed;

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

15. Establish a budget and make expenditures;

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

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

audits and any recommendations that may have been adopted by the interstate commission;

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

19. Maintain records in accordance with the bylaws;

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

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

§ 8873. Finance powers. 1. The interstate commission may levy on and collect an annual assessment from each member state to cover the cost of the operations and activities of the interstate commission and its staff. The total assessment must be sufficient to cover the annual budget approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated upon a formula to be determined by the interstate commission, which shall promulgate a rule binding upon all member states.

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

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

4. The interstate commission shall be subject to a yearly financial audit conducted by a certified or licensed public accountant and the report of the audit shall be included in the annual report of the interstate commission.

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

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

2. The interstate commission shall elect or appoint annually from among its commissioners a chairperson, a vice-chairperson, and a treasurer, each of whom shall have such authority and duties as may be specified in the bylaws. The chairperson, or in the chairperson's absence or disability, the vice-chairperson, shall preside at all meetings of the interstate commission.

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

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

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

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

(b) The interstate commission shall defend the executive director, its employees, and subject to the approval of the attorney general or other appropriate legal counsel of the member state represented by an interstate commission representative, shall defend such interstate commission representative in any civil action seeking to impose liability arising out of an actual or alleged act, error or omission that occurred within the scope of interstate commission employment, duties or responsibilities, or that the defendant had a reasonable basis for believing occurred within the scope of interstate commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from intentional or willful and wanton misconduct on the part of such person.

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

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

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

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

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

§ 8876. Oversight of interstate compact. 1. The executive, legislative, and judicial branches of state government in each member state shall enforce the compact and shall take all actions necessary and appropriate to effectuate the compact's purposes and intent. The provisions of the compact and the rules promulgated hereunder shall have standing as statutory law but shall not override existing state authority to regulate the practice of medicine.

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

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

§ 8877. Enforcement of interstate compact. 1. The interstate commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of the compact.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. The compact shall become effective and binding upon legislative enactment of the compact into law by no less than seven states. Thereafter, it shall become effective and binding on a state upon enactment of the compact into law by that state.

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

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

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

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

3. The withdrawing state shall immediately notify the chairperson of the interstate commission in writing upon the introduction of legislation repealing the compact in the withdrawing state.

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

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

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

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

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

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

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

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

3. Nothing in the compact shall be construed to prohibit the applicability of other interstate compacts to which the states are members.

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

2. All laws in a member state in conflict with the compact are superseded to the extent of the conflict.

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

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

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

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

ARTICLE 170

NURSE LICENSURE COMPACT

Section 8900. Nurse licensure compact.

8911. Construction and severability.

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

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

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

b. Violations of nurse licensure and other laws regulating the practice of nursing may result in injury or harm to the public;

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

d. New practice modalities and technology make compliance with individual state nurse licensure laws difficult and complex;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

e. "Current significant investigative information" means:

1. Investigative information that a licensing board, after a preliminary inquiry that includes notification and an opportunity for the nurse to respond, if required by state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction; or

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

f. "Encumbrance" means a revocation or suspension of, or any limitation on, the full and unrestricted practice of nursing imposed by a licensing board.

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

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

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

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

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

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

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

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

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

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

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

b. A state shall implement procedures for considering the criminal history records of applicants for an initial multistate license or licensure by endorsement. Such procedures shall include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant's criminal history record information from the federal bureau of investigation and the agency responsible for retaining that state's criminal records.

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

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

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

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

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

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

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

vi. Has submitted, in connection with an application for initial licensure or licensure by endorsement, fingerprints or other biometric data for the purpose of obtaining criminal history record information from the federal bureau of investigation and the agency responsible for retaining that state's criminal records;

vii. Has not been convicted or found guilty, or has entered into an agreed disposition, of a felony offense under applicable state or federal criminal law;

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

ix. Is not currently enrolled in an alternative program;

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

xi. Has a valid United States social security number.

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

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

f. Individuals not residing in a party state shall continue to be able to apply for a party state's single-state license as provided under the laws of each party state. However, the single-state license granted to

these individuals will not be recognized as granting the privilege to practice nursing in any other party state. Nothing in this compact shall affect the requirements established by a party state for the issuance of a single-state license.

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

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

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

§ 8904. Applications for licensure in a party state. 1. Applications for licensure in a party state. a. Upon application for a multistate license, the licensing board in the issuing party state shall ascertain, through the coordinated licensure information system, whether the applicant has ever held, or is the holder of, a license issued by any other state, whether there are any encumbrances on any license or multistate licensure privilege held by the applicant, whether any adverse action has been taken against any license or multistate licensure privilege held by the applicant and whether the applicant is currently participating in an alternative program.

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

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

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

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

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

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

a. Take adverse action against a nurse's multistate licensure privilege to practice within that party state.

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

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

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

c. Complete any pending investigations of a nurse who changes primary state of residence during the course of such investigations. The licensing board shall also have the authority to take appropriate action or actions and shall promptly report the conclusions of such investigations to the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the new home state of any such actions.

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

e. Obtain and submit, for each nurse licensure applicant, fingerprint or other biometric-based information to the federal bureau of investigation for criminal background checks, receive the results of the federal bureau of investigation record search on criminal background checks and use the results in making licensure decisions.

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

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

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

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

§ 8906. Coordinated licensure information system and exchange of information. 1. Coordinated licensure information system and exchange of information. a. All party states shall participate in a coordinated licensure information system of all licensed registered nurses (RNs) and licensed practical/vocational nurses (LPNs/VNs). This system will include information on the licensure and disciplinary history of each nurse, as submitted by party states, to assist in the coordination of nurse licensure and enforcement efforts.

b. The commission, in consultation with the administrator of the coordinated licensure information system, shall formulate necessary and proper procedures for the identification, collection and exchange of information under this compact.

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

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

e. Notwithstanding any other provision of law, all party state licensing boards contributing information to the coordinated licensure information system may designate information that may not be shared with non-party states or disclosed to other entities or individuals without the express permission of the contributing state.

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

g. Any information contributed to the coordinated licensure information system that is subsequently required to be expunged by the laws of the party state contributing that information shall also be expunged from the coordinated licensure information system.

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

i. Identifying information;

ii. Licensure data;

iii. Information related to alternative program participation; and

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

i. The compact administrator of a party state shall provide all investigative documents and information requested by another party state.

§ 8907. Establishment of the interstate commission of nurse licensure compact administrators. 1. Commission of nurse licensure compact administrators. The party states hereby create and establish a joint public entity known as the interstate commission of nurse licensure compact administrators. The commission is an instrumentality of the party states.

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

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

4. Membership, voting and meetings. a. Each party state shall have and be limited to one administrator. The head of the state licensing board or designee shall be the administrator of this compact for each party state. Any administrator may be removed or suspended from office as provided by the law of the state from which the administrator is appointed. Any vacancy occurring in the commission shall be filled in accordance with the laws of the party state in which the vacancy exists.

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

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

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

5. Closed meetings. a. The commission may convene in a closed, nonpublic meeting if the commission shall discuss:

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

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

iii. Current, threatened or reasonably anticipated litigation;

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

v. Accusing any person of a crime or formally censuring any person;

vi. Disclosure of trade secrets or commercial or financial information that is privileged or confidential;

vii. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

viii. Disclosure of investigatory records compiled for law enforcement purposes;

ix. Disclosure of information related to any reports prepared by or on behalf of the commission for the purpose of investigation of compliance with this compact; or

x. Matters specifically exempted from disclosure by federal or state statute.

b. If a meeting, or portion of a meeting, is closed pursuant to this paragraph the commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefor, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the commission or order of a court of competent jurisdiction.

c. The commission shall, by a majority vote of the administrators, prescribe bylaws or rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of this compact, including but not limited to:

i. Establishing the fiscal year of the commission;

ii. Providing reasonable standards and procedures:

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

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

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

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

v. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the commission. Notwithstanding any civil service or other similar laws of any party state, the bylaws shall exclusively govern the personnel policies and programs of the commission; and

vi. Providing a mechanism for winding up the operations of the commission and the equitable disposition of any surplus funds that may exist after the termination of this compact after the payment or reserving of all of its debts and obligations.

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

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

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

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

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

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

c. To purchase and maintain insurance and bonds;

d. To borrow, accept or contract for services of personnel, including, but not limited to, employees of a party state or nonprofit organizations;

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

f. To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of this compact, and to establish the commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel and other related personnel matters;

g. To accept any and all appropriate donations, grants and gifts of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the commission shall avoid any appearance of impropriety or conflict of interest;

h. To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, whether real,

personal or mixed; provided that at all times the commission shall avoid any appearance of impropriety;

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

j. To establish a budget and make expenditures;

k. To borrow money;

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

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

n. To adopt and use an official seal; and

o. To perform such other functions as may be necessary or appropriate to achieve the purposes of this compact consistent with the state regulation of nurse licensure and practice.

8. Financing of the commission. a. The commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization and ongoing activities.

b. The commission may also levy on and collect an annual assessment from each party state to cover the cost of its operations, activities and staff in its annual budget as approved each year. The aggregate annual assessment amount, if any, shall be allocated based upon a formula to be determined by the commission, which shall promulgate a rule that is binding upon all party states.

c. The commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the commission

pledge the credit of any of the party states, except by, and with the authority of, such party state.

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

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

b. The commission shall defend any administrator, officer, executive director, employee or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of the commission's employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of the commission's employment, duties or

responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further that the actual or alleged act, error or omission did not result from that person's intentional, willful or wanton misconduct.

c. The commission shall indemnify and hold harmless any administrator, officer, executive director, employee or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of the commission's employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of the commission's employment, duties or responsibilities, provided that the actual or alleged act, error or omission did not result from the intentional, willful or wanton misconduct of that person.

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

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

2. Notice. a. Prior to promulgation and adoption of a final rule or rules by the commission, and at least sixty days in advance of the meeting at which the rule will be considered and voted upon, the commission shall file a notice of proposed rulemaking:

i. On the website of the commission; and

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

b. The notice of proposed rulemaking shall include:

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

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

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

iv. The manner in which interested persons may submit notice to the commission of their intention to attend the public hearing and any written comments.

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

3. Public hearings on rules. a. The commission shall grant an opportunity for a public hearing before it adopts a rule or amendment.

b. The commission shall publish the place, time and date of the scheduled public hearing.

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

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

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

d. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the commission shall consider all written and oral comments received.

4. Voting on rules. The commission shall, by majority vote of all administrators, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

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

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

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

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

6. Revisions. The commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency or grammatical errors. Public notice of any revisions shall be posted on the website of the commission. The revision shall be subject to challenge by any person for a period of thirty days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing, and delivered to the commission, prior to the end of the notice period. If no challenge is

made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the commission.

§ 8909. Oversight, dispute resolution and enforcement. 1. Oversight. a. Each party state shall enforce this compact and take all actions necessary and appropriate to effectuate this compact's purposes and intent.

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

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

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

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

b. If a state in default fails to cure the default, the defaulting state's membership in this compact may be terminated upon an affirmative vote of a majority of the administrators, and all rights, privileges and benefits conferred by this compact may be terminated on the effective date of termination. A cure of the default does not relieve the offend-

ing state of obligations or liabilities incurred during the period of default.

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

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

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

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

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

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

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

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

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

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

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

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

§ 8910. Effective date, withdrawal and amendment. 1. Effective date. a. This compact shall become effective and binding on the earlier of the date of legislative enactment of this compact into law by no less than twenty-six states or the effective date of the chapter of the laws of two thousand twenty-four that enacted this compact. Thereafter, the compact shall become effective and binding as to any other compacting state upon enactment of the compact into law by that state. All party states to this compact, that also were parties to the prior nurse licen-

sure compact, superseded by this compact, (herein referred to as "prior compact"), shall be deemed to have withdrawn from said prior compact within six months after the effective date of this compact.

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

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

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

c. Nothing contained in this compact shall be construed to invalidate or prevent any nurse licensure agreement or other cooperative arrangement between a party state and a non-party state that is made in accordance with the other provisions of this compact.

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

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

§ 8911. Construction and severability. 1. Construction and severability. This compact shall be liberally construed so as to effectuate the

purposes thereof. The provisions of this compact shall be severable, and if any phrase, clause, sentence or provision of this compact is declared to be contrary to the constitution of any party state or of the United States, or if the applicability thereof to any government, agency, person or circumstance is held to be invalid, the validity of the remainder of this compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this compact shall be held to be contrary to the constitution of any party state, this compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters.

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

PART S

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

§ 2825-i. Healthcare safety net transformation program. 1. A statewide healthcare safety net transformation program shall be established within the department for the purpose of supporting the transformation of safety net hospitals to improve access, equity, quality, and outcomes while increasing the financial sustainability of safety net hospitals. Such program may provide or utilize new or existing capital funding, or operating subsidies, or both. A safety net hospital and a partner organization may jointly apply for this program.

2. The commissioner shall enter an agreement with the president of the dormitory authority of the state of New York pursuant to section sixteen

hundred eighty-r of the public authorities law, as required, which shall apply to this agreement, subject to the approval of the director of the division of the budget, for the purposes of the distribution and administration of available funds pursuant to such agreement and made available pursuant to this section and subject to appropriation. Such funds may be awarded and distributed by the department to safety net hospitals, or a partner organization, in the form of grants. To qualify as a safety net hospital for purposes of this section, a hospital shall:

(a) be either a public hospital, a rural emergency hospital, critical access hospital or sole community hospital;

(b) have at least thirty percent of its inpatient discharges made up of medical assistance program eligible individuals, uninsured individuals or medical assistance program dually eligible individuals and at least thirty-five percent of its outpatient visits made up of medical assistance program eligible individuals, uninsured individuals or medical assistance program dually-eligible individuals;

(c) serve at least thirty percent of the residents of a county or a multi-county area who are medical assistance program eligible individuals, uninsured individuals or medical assistance program dually-eligible individuals; or

(d) in the discretion of the commissioner, serve a significant population of medical assistance program eligible individuals, uninsured individuals or medical assistance program dually-eligible individuals.

3. Partner organizations may include, but are not limited to, health systems, hospitals, health plans, residential health care facilities, physician groups, community-based organization, or other healthcare entities who can serve as partners in the transformation of the safety net hospital. The commissioner shall have the discretion to deem any

organization a partner organization upon a finding that deeming so will advance the goals of this section.

4. Notwithstanding any law to the contrary, and in accordance with article four of the state finance law, the comptroller is hereby authorized and directed to transfer, upon request of the director of budget, on or before March thirty-first, two thousand twenty-five, up to five hundred million dollars to the department from amounts appropriated to administer the programs established in sections twenty-eight hundred twenty-five-g and twenty-eight hundred twenty-five-h of this article to support this program. Notwithstanding section one hundred sixty-three of the state finance law, sections one hundred forty-two and one hundred forty-three of the economic development law or any inconsistent provisions of law to the contrary, awards may be provided without a competitive bid or request for proposal process to safety net hospitals or partner organizations for purposes of increasing access, equity, quality, outcomes, and long-term financial sustainability of such safety net hospitals.

5. Notwithstanding any provision of law to the contrary, the commissioner is authorized to waive any regulatory requirements to allow applicants to more effectively or efficiently implement projects awarded through the healthcare safety net transformation program, provided, however, that regulations pertaining to patient safety, patient autonomy, patient privacy, patient rights, due process, scope of practice, professional licensure, environmental protections, provider reimbursement methodologies, or occupational standards and employee rights may not be waived, nor shall any regulations be waived if such waiver would risk patient safety. Such waiver shall not exceed the life of the project or such shorter time periods as the commissioner may determine.

Any regulatory relief granted pursuant to this subdivision shall be specifically described and requested within each project application and be reviewed by the commissioner. The waiver of any regulatory requirements shall be made in the sole discretion of the commissioner.

6. Qualifying safety net hospitals and their designated partner organization or organizations shall provide, as part of the application, which shall be in a manner as prescribed by the commissioner, a transformation plan that includes at least a five-year strategic and operational plan outlining the roles and responsibilities of each entity and specifically state any regulatory flexibility which may be required to implement such plan. The transformation plan shall also include a timeline of key metrics and goals related to improved access, equity, quality, outcomes, and increased financial sustainability of the safety net hospital. The request for level and type of support shall be specific and detailed in the application. Continued support shall be contingent upon the implementation of the approved plan and key milestones. Applications may include a range of collaboration models, including but not be limited to merger, acquisition, a management services contract, or a clinical integration.

7. The release of any funding will be contingent upon compliance with the transformation plan and a determination that acceptable progress has been made with such plan. If key milestones and goals are not met, additional financial resources may be withheld and redirected, upon the recommendation of the commissioner and approval by the director of budget.

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

PART T

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

1. (a) Every physician or other person authorized by law to order diagnostic tests or make a medical diagnosis, or any laboratory performing such tests shall immediately [(a)] (i) upon determination that a person is [infected] positive/reactive with human immunodeficiency virus (HIV), [(b)] (ii) upon diagnosis [that a person is afflicted] with [the disease known as] acquired immune deficiency syndrome (AIDS), [(c)] (iii) upon diagnosis [that a person is afflicted] with HIV related illness, and [(d)] (iv) upon periodic monitoring of HIV infection by any laboratory tests report such case or data to the commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. [A person authorized pursuant to law to order the performance of an HIV related test shall provide directly or through a representative to the person seeking such test, an opportunity to remain anonymous through use of a coded system with no linking of individual identity to the test request or results.] A health care provider who is not authorized by the commissioner to provide HIV related tests on an anonymous basis shall

refer a person who requests an anonymous test to a test site which does provide anonymous testing. The provisions of this subdivision shall not apply to a health care provider ordering the performance of an HIV related test on an individual proposed for insurance coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) in situations involving occupational exposures which create a significant risk of contracting or transmitting HIV infection, as

defined in regulations of the department and pursuant to protocols adopted by the department,

(i) provided that:

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

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

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

(ii) in which case

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

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

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

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

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

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

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

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

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

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

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

(i) ensure that the patient is HIV negative, as documented by a negative HIV test result obtained within the previous seven days from an HIV antigen/antibody test or antibody-only test or from a rapid, point-of-care fingerstick blood test approved by the federal food and drug administration. If the patient does not provide evidence of a negative HIV test in accordance with this paragraph, the pharmacist may recommend or

prescribe an HIV test. If the patient tests positive for HIV infection, the pharmacist shall direct the patient to a licensed physician and provide the patient with a list of health care service providers and clinics within the county where the pharmacist is located or adjacent counties;

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

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

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

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

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

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

11. A licensed pharmacist within their lawful scope of practice may administer to patients eighteen years of age or older, immunizing agents to prevent mpox pursuant to a patient specific order or a non-patient specific order. When a licensed pharmacist administers an mpox immunizing agent, they shall comply with subdivisions two, three and four of this section.

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

§ 10. This act shall take effect immediately; provided, however, sections one, two, and three of this act shall take effect on the one hundred eightieth day after it shall have become a law. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

PART U

Section 1. Section 3302 of the public health law is amended by adding two new subdivisions 42 and 43 to read as follows:

42. "Public health surveillance" means the continuous, systematic collection, analysis, and interpretation of health-related data needed for the planning, implementation, and evaluation of public health prac-

tice. Public health surveillance may be used for all of the following purposes:

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

(b) to document the impact of an intervention;

(c) to track progress towards specified goals;

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

(e) to establish public health priorities; and

(f) to inform public health policy and strategies.

43. "Patient identifying information" means information or direct identifiers and demographic information that can be used to readily identify a particular patient as may be specified in more detail in regulations promulgated by the commissioner.

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

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

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

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

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

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

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

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

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

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

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

(c) to an agency, department of government, or official board authorized to regulate, license or otherwise supervise a person who is author-

ized by this article to deal in controlled substances, or in the course of any investigation or proceeding by or before such agency, department or board;

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

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

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

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

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

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

(i) pursuant to an agreement with the commissioner;

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

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

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

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

(j) to a local health department for the purpose of conducting public health research, public health surveillance or education and not for patient-level outreach: (i) pursuant to an agreement with the commissioner; (ii) when the release of such information is deemed appropriate by the commissioner; (iii) for use in accordance with measures required by the commissioner to ensure that the security and confidentiality of the data is protected; (iv) for use and retention no longer than ten years; and [(iv)] (v) provided that disclosure is restricted to individuals within the local health department who are engaged in the research or education;

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

[(j)] (l) to an individual for the purpose of providing such individual with his or her own controlled substance history or, in appropriate circumstances, in the case of a patient who lacks capacity to make health care decisions, a person who has legal authority to make such decisions for the patient and who would have legal access to the

patient's health care records, if requested from the department pursuant to subdivision six of section thirty-three hundred forty-three-a of this article or from a treating practitioner pursuant to subparagraph (iv) of paragraph (a) of subdivision two of this section.

§ 5. Subdivision (b) of schedule I of section 3306 of the public health law is amended by adding eleven new paragraphs 93, 94, 95, 96, 97, 98, 99, 100, 101, 102 and 103 to read as follows:

(93) Zipeprol (1-methoxy-3-[4-(2-methoxy-2-phenylethyl)piperazin-1-yl]-1-phenylpropan-2-ol).

(94) N,N-diethyl-2-(2-(4-methoxybenzyl)-5-nitro-1H-benzimidazol-1-yl)ethan-1-amine. Some trade or other names: Metonitazene.

(95) meta-fluorofentanyl(N-(3-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)propionamide).

(96) meta-fluoroisobutyryl fentanyl(N-(3-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide).

(97) para-methoxyfuranyl fentanyl (N-(4-methoxyphenyl)-N-(1-phenethylpiperidin-4-yl)furan-2-carboxamide).

(98) 3-furanyl fentanyl(N-(1-phenethylpiperidin-4-yl)-N-phenylfuran-3-carboxamide).

(99) 2',5'-dimethoxyfentanyl(N-(1-(2,5-dimethoxyphenethyl)piperidin-4-yl)-N-phenylpropionamide).

(100) Isovaleryl fentanyl(3-methyl-N-(1-phenethylpiperidin-4-yl)-N-phenylbutanamide).

(101) ortho-fluorofuranyl fentanyl(N-(2-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)furan-2-carboxamide).

(102) alpha'-methyl butyryl fentanyl(2-methyl-N-(1-phenethylpiperidin-4-yl)-N-phenylbutanamide).

(103) para-methylcyclopropyl fentanyl (N-(4-methylphenyl)-N-(1-phenethylpiperidin-4-yl)cyclopropanecarboxamide).

§ 6. Paragraphs 11 and 36 of subdivision (d) of schedule I of section 3306 of the public health law, paragraph 11 as added by chapter 664 of the laws of 1985 and paragraph 36 as added by section 5 of part BB of chapter 57 of the laws of 2018, are amended to read as follows:

(11) [Ibogane] Ibogaine. Some trade and other names: 7-ethyl-6, 6&, 7, 8, 9, 10, 12, 13-octahydro-2-methoxy-6, 9-methano-5h-pyrido {1',2':1,2} azepino {5,4-b} indole: tabernanthe iboga.

(36) 5-methoxy-N,N-dimethyltryptamine. Some trade or other names: 5-methoxy-3-[2-(dimethylamino)ethyl]indole; 5-MeO-DMT.

§ 7. Subdivision (d) of schedule I of section 3306 of the public health law is amended by adding nineteen new paragraphs 32, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55 and 56 to read as follows:

(32) 4-methyl-N-ethylcathinone. Some trade or other names: 4-MEC.

(39) 4-methyl-alpha-pyrrolidinopropiophenone. Some trade or other names: 4-MePPP.

(40) Alpha-pyrrolidinopentiophenone. Some trade or other names: @-PVP.

(41) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)butan-1-one. Some trade or other names: Butylone; bk-MBDB.

(42) 2-(methylamino)-1-phenylpentan-1-one. Some trade or other names: Pentedrone.

(43) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)pentan-1-one. Some trade or other names: Pentylone; bk-MBDP.

(44) 1-(naphthalen-2-yl)-2-(pyrrolidin-1-yl)pentan-1-one. Some trade or other names: Naphyrone.

(45) Alpha-pyrrolidinobutiophenone. Some trade or other names: @-PBP.

(46) 1-(1,3-benzodioxol-5-yl)-2-(ethylamino)propan-1-one (ethylone).

(47) N-ethylpentylone. Some trade or other names: ephylone, 1-(1,3-benzodioxol-5-yl)-2-(ethylamino)pentan-1-one).

(48) 1-(4-methoxyphenyl)-N-methylpropan-2-amine. Some trade or other names: para-methoxymethamphetamine; PMMA.

(49) N-Ethylhexedrone. Some trade or other names: @-ethylaminohexanophenone; 2-(ethylamino)-1-phenylhexan-1-one.

(50) alpha-Pyrrolidinohexanophenone. Some trade or other names: @-PHP; alpha-pyrrolidinohexanophenone; 1-phenyl-2-(pyrrolidin-1-yl)hexan-1-one.

(51) 4-Methyl-alpha-ethylaminopentiophenone. Some trade or other names: 4-MEAP; 2-(ethylamino)-1-(4-methylphenyl)pentan-1-one.

(52) 4'-Methyl-alpha-pyrrolidinohexiophenone. Some trade or other names: MPHP; 4'-methyl-alpha-pyrrolidinohexanophenone; 1-(4-methylphenyl)-2-(pyrrolidin-1-yl)hexan-1-one.

(53) alpha-Pyrrolidinoheptaphenone. Some trade or other names: PV8; 1-phenyl-2-(pyrrolidin-1-yl)heptan-1-one.

(54) 4-Chloro-alpha-pyrrolidinovalerophenone. Some trade or other names: 4-chloro-@-PVP; 4'-chloro-alpha-pyrrolidinopentiophenone; 1-(4-chlorophenyl)-2-(pyrrolidin-1-yl)pentan-1-one.

(55) 2-(ethylamino)-2-(3-methoxyphenyl)cyclohexan-1-one (methoxetamine, MXE).

(56) 1-(1,3-benzodioxol-5-yl)-2-(ethylamino)butan-1-one. Some trade or other names: eutylone; bk-EBDB.

§ 8. Subdivision (e) of schedule I of section 3306 of the public health law is amended by adding five new paragraphs 7, 8, 9, 10 and 11 to read as follows:

(7) 4-(2-chlorophenyl)-2-ethyl-9-methyl-6H-thieno{3,2-f}{1,2,4}triazolo{4,3-a}{1,4}diazepine. Some trade or other names: etizolam.

(8) 8-chloro-6-(2-fluorophenyl)-1-methyl-4H-benzo{f}{1,2,4}triazolo{4,3-a}{1,4}diazepine. Some trade or other names: flualprazolam.

(9) 6-(2-chlorophenyl)-1-methyl-8-nitro-4H-benzo{f}{1,2,4}triazolo{4,3-a}{1,4}diazepine. Some trade or other names: clonazolam.

(10) 8-bromo-6-(2-fluorophenyl)-1-methyl-4H-benzo{f}{1,2,4}triazolo{4,3-a}{1,4}diazepine (alternate chemical name: 8-bromo-6-(2-fluorophenyl)-1-methyl-4H-{1,2,4}triazolo{4,3-a}{1,4}benzodiazepine). Some trade or other names: flubromazolam.

(11) 7-chloro-5-(2-chlorophenyl)-1-methyl-1,3-dihydro-2H-benzo{e}{1,4}diazepin-2-one. Some trade or other names: diclazepam.

§ 9. Paragraphs 13 and 14 of subdivision (f) of schedule I of section 3306 of the public health law, as added by chapter 341 of the laws of 2013, are amended and four new paragraphs 25, 26, 27 and 28 are added to read as follows:

(13) 3-Fluoromethcathinone. Some trade or other names: 3-fluoro-N-methylcathinone; 3-FMC.

(14) 4-Fluoromethcathinone. Some trade or other names: 4-fluoro-N-methylcathinone; 4-FMC; flephedrone.

(25) 7-[(10,11-dihydro-5H-dibenzo]a,d[cyclohepten-5-yl)amino]heptanoic acid. Other name: amineptine.

(26) N-phenyl-N'-(3-(1-phenylpropan-2-yl)-1,2,3-oxadiazol-3-ium-5-yl)carbamimidate. Other name: mesocarb.

(27) N-methyl-1-(thiophen-2-yl)propan-2-amine. Other name: methiopropamine.

(28) 4,4'-Dimethylaminorex. Some trade or other names: 4,4'-DMAR; 4,5-dihydro-4-methyl-5-(4-methylphenyl)-2-oxazolamine; 4-methyl-5-(4 methylphenyl)-4,5-dihydro-1,3-oxazol-2-amine.

§ 10. Paragraphs 2, 6 and 10 of subdivision (g) of schedule I of section 3306 of the public health law, as added by section 7 of part BB of chapter 57 of the laws of 2018, are amended to read as follows:

(2) {1-(5-fluro-pentyl)-1H-indol-3-yl}(2,2,3,3-tetramethylcyclopropyl) methanone. Some trade names or other names: 5-fluoro-UR-144[,]; XLR11.

(6) N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)-1H-indazo [-] le-3-carboxamide. Some trade or other names: AB-FUBINACA.

(10) {1-(5-fluoropentyl)-1H-indazol-3-yl}(naphthalen-1-[y1] yl)metha- none. Some trade or other names: THJ-2201.

§ 11. Subdivision (g) of schedule I of section 3306 of the public health law is amended by adding nineteen new paragraphs 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28 and 29 to read as follows:

(11) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)-1H-indazole-3-carboxamide. Some trade or other names: MAB-CHMINACA; ADB-CHMINACA.

(12) methyl 2-(1-(4-fluorobenzyl)-1H-indazole-3-carboxamido)-3-methylbutanoate. Some trade or other names: FUB-AMB; MMB-FUBINACA; AMB-FUBINACA.

(13) methyl 2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido)-3,3-dimethylbutanoate. Some trade or other names: MDMB-CHMICA; MMB-CHMINACA.

(14) methyl 2-(1-(4-fluorobenzyl)-1H-indazole-3-carboxamido)-3,3-dimethylbutanoate. Some trade or other names: MDMB-FUBINACA.

(15) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)-1H-indazole-3-carboxamide. Some trade or other names: ADB-FUBINACA.

(16) N-(adamantan-1-yl)-1-(5-fluoropentyl)-1H-indazole-3-carboxamide. Some trade or other names: 5F-APINACA; 5F-AKB48.

(17) methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3-methylbutanoate. Some trade or other names: 5F-AMB.

(18) methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3,3-dimethylbutanoate. Some trade or other names: 5F-ADB; 5F-MDMB-PINACA.

(19) Naphthalen-1-yl 1-(5-fluoropentyl)-1H-indole-3-carboxylate. Some trade or other names: NM2201; CBL2201.

(20)N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)-1H-indazole-3-carboxamide. Some trade or other names: 5F-AB-PINACA.

(21) 1-(4-cyanobutyl)-N-(2-phenylpropan-2-yl)-1H-indazole-3-carboxamide. Some trade or other names: 4-CN-CUMYL-BUTINACA; 4-cyano-CUMYL- BUTINACA;4-CN-CUMYL BINACA; CUMYL-4CN-BINACA; SGT-78.

(22) methyl 2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido)-3-methylbutanoate. Some trade or other names: MMB-CHMICA; AMB-CHMICA.

(23) 1-(5-fluoropentyl)-N-(2-phenylpropan-2-yl)-1H-pyrrolo{2,3-b}pyridine-3-carboxamide. Some trade or other names: 5F-CUMYL-P7AICA.

(24) methyl 2-(1-(4-fluorobutyl)-1H-indazole-3-carboxamido)-3,3-dimethylbutanoate. Some trade or other names: 4F-MDMB-BINACA; 4F-MDMB-BUTINACA.

(25) ethyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3,3-dimethylbutanoate. Some trade or other names: 5F-EDMB-PINACA.

(26) methyl 2-(1-(5-fluoropentyl)-1H-indole-3-carboxamido)-3,3-dimethylbutanoate. Some trade or other names: 5F-MDMB-PICA; 5F-MDMB-2201.

(27) N-(adamantan-1-yl)-1-(4-fluorobenzyl)-1H-indazole-3-carboxamide. Some trade or other names: FUB-AKB48; FUB-APINACA; AKB48 N-(4-FLUOROBENZYL).

(28) 1-(5-fluoropentyl)-N-(2-phenylpropan-2-yl)-1H-indazole-3-carboxamide. Some trade or other names: 5F-CUMYL-PINACA; SGT-25.

(29) (1-4-fluorobenzyl)-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl) methanone. Some trade or other names: FUB-144.

§ 12. Paragraph 1 of subdivision (b) of schedule II of section 3306 of the public health law, as amended by section 1 of part C of chapter 447 of the laws of 2012, is amended to read as follows:

(1) Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate, excluding apomorphine, dextrorphan, nalbuphine, naldemedine, nalmefene, naloxefol, naloxone, [and] 6&-naltrexol, naltrexone, and samidorphan, and their respective salts, but including the following:

1. Raw opium.

2. Opium extracts.

3. Opium fluid.

4. Powdered opium.

5. Granulated opium.

6. Tincture of opium.

7. Codeine.

8. Ethylmorphine.

9. Etorphine hydrochloride.

10. Hydrocodone (also known as dihydrocodeinone).

11. Hydromorphone.

12. Metopon.

13. Morphine.

14. Oxycodone.

15. Oxymorphone.

16. Thebaine.

17. Dihydroetorphine.

18. Oripavine.

19. Noroxymorphone.

§ 13. Subdivision (c) of schedule II of section 3306 of the public health law is amended by adding a new paragraph 30 to read as follows:

30. Oliceridine. (N-{(3-methoxythiophen-2-yl)methyl}({2-{(9R)-9-(pyridin-2-yl)-6-oxaspiro{4.5}decan-9-yl}ethyl})amine).

§ 14. Subdivision (f) of schedule II of section 3306 of the public health law, as amended by chapter 589 of the laws of 1996, the undesignated paragraph as amended by chapter 575 of the laws of 2001, is amended to read as follows:

(f) Hallucinogenic substances.

(1) Nabilone: Another name for nabilone: (+,-)-trans-3-(1,1-dimethylheptyl)-6, 6a, 7, 8, 10, 10a-hexahydro-1-hydroxy-6, 6-dimethyl-9H-dibenzo{b,d}pyran-9-one.

(2) Dronabinol {(-)-delta-9-trans tetrahydrocannabinol} in an oral solution in a drug product approved for marketing by the United States Food and Drug Administration.

§ 15. Subparagraph (i) of paragraph 3 of subdivision (g) of schedule II of section 3306 of the public health law, as amended by section 2 of part BB of chapter 57 of the laws of 2023, is amended to read as follows:

(i) [4-anilino-N-phenenethylpiperidine] 4-anilino-N-phenethylpiperidine (ANPP).

§ 16. Subdivision (h) of schedule II of section 3306 of the public health law, as amended by section 8 of part C of chapter 447 of the laws of 2012, is amended to read as follows:

(h) (1) Anabolic steroids. Unless specifically excepted or unless listed in another schedule, "anabolic steroid" shall mean any drug or hormonal substance, chemically and pharmacologically related to testos-

terone (other than estrogens, progestins, corticosteroids and dehydroepiandrosterone) and includes:

[(1)] (i) 3{beta}, 17-dihydroxy-5a-androstane.

[(2)] (ii) 3{alpha}, 17{beta}-dihydroxy-5a-androstane.

[(3)] (iii) 5{alpha}-androstan-3,17-dione.

[(4)] (iv) 1-androstenediol (3{beta},17{beta}-dihydroxy-5{alpha}-androst-1- ene).

[(5)] (v) 1-androstenediol (3{alpha},17{beta}-dihydroxy-5{alpha}-androst-1- ene).

[(6)] (vi) 4-androstenediol (3{beta}, 17{beta}-dihydroxy-androst-4-ene).

[(7)] (vii) 5-androstenediol (3{beta}, 17{beta}-dihydroxy- androst-5-ene).

[(8)] (viii) 1-androstenedione ({5{alpha}}-androst-1-en-3, 17-dione).

[(9)] (ix) 4-androstenedione (androst-4-en-3,17-dione).

[(10)] (x) 5-androstenedione (androst-5-en-3,17-dione).

[(11)] (xi) Bolasterone (7{alpha},17{alpha}-dimethyl-17{beta} -hydroxyandrost-4-en-3-one).

[(12)] (xii) Boldenone (17{beta}-hydroxyandrost-1, 4,-diene -3-one).

[(13)] (xiii) Boldione (androsta-1,4-diene-3,17-dione).

[(14)] (xiv) Calusterone (7{beta}, 17{alpha}-dimethyl-17{beta}-hydroxyandrost- 4-en-3-one).

[(15)] (xv) Clostebol (4-chloro-17{beta}-hydroxyandrost-4-e n-3-one).

[(16)] (xvi) Dehydrochloromethyltestosterone (4-chloro-17{beta}-hydroxy-17{alpha}-methyl-androst-1, 4-dien-3-one).

[(17)] (xvii) {Delta} 1-dihydrotestosterone (a.k.a. '1-testosterone')(17{beta}-hydroxy-5{alpha}-androst-1-en-3-one).

[(18)] (xviii) 4-dihydrotestosterone (17{beta}-hydroxy-androstan-3-one).

[(19)] (xix) Drostanolone (17{beta}-hydroxy-2{alpha}-methyl -5{alpha} -androstan-3-one).

[(20)] (xx) Ethylestrenol (17{alpha}-ethyl-17{beta}-hydroxy estr-4-ene).

[(21)] (xxi) Fluoxymesterone (9-fluoro-17{alpha}-methyl-11{beta}, 17 {beta}-dihydroxyandrost-4-en-3-one).

[(22)] (xxii) Formebolone (2-formyl-17{alpha}-methyl-11{alpha}, 17{beta}-dihydroxyandrost-1, 4-dien-3-one).

[(23)] (xxiii) Furazabol (17{alpha}-methyl-17{beta}-hydroxyandros tano {2, 3-c}-furazan).

[(24)] (xxiv) 13{beta}-ethyl-17{beta}-hyroxygon-4-en-3-one.

[(25)] (xxv) 4-hydroxytestosterone (4, 17{beta}-dihydroxy-androst-4-en-3-one).

[(26)] (xxvi) 4-hydroxy-19-nortestosterone (4,17{beta}-dihydroxy-estr-4-en-3-one).

[(27)] (xxvii) desoxymethyltestosterone (17{alpha}-methyl-5 {alpha}-androst-2-en-17{beta}-ol) (a.k.a., madol).

[(28)] (xxviii) Mestanolone (17{alpha}-methyl-17{beta}- hydroxy- 5-an-drostan-3-one).

[(29)] (xxix) Mesterolone (1{alpha}methyl-17{beta}-hydroxy-{5{alpha}}-androstan-3-one).

[(30)] (xxx) Methandienone (17{alpha}-methyl-17{beta}-hydroxyandr ost-1, 4-dien-3-one).

[(31)] (xxxi) Methandriol (17{alpha}-methyl-3{beta}, 17 {beta}-dihydroxyandrost-5-ene).

[(32)] (xxxii) Methenolone (1-methyl- 17{beta}-hydroxy-5 {alpha}-androst- 1-en-3-one).

[(33)] (xxxiii) 17{alpha}-methyl-3{beta},17{beta}-dihydroxy - 5a-androstane.

[(34)] (xxxiv) 17{alpha}-methyl-3{alpha}, 17{beta}- dihydroxy- 5a-androstane

[(35)] (xxxv) 17{alpha}-methyl-3{beta}, 17{beta}-dihydroxyandrost -4-ene.

[(36)] (xxxvi) 17{alpha}-methyl-4-hydroxynandrolone (17{alpha}-methyl-4-hydroxy-17{beta}-hydroxyestr-4-en-3-one).

[(37)] (xxxvii) Methyldienolone (17{alpha}-methyl-17{beta}- hydroxyestra- 4,9(10)-dien-3-one).

[(38)] (xxxviii) Methyltrienolone (17{alpha}-methyl-17{beta}-hyd roxyestra-4, 9-11-trien-3-one).

[(39)] (xxxix) Methyltestosterone(17{alpha}-methyl-17{beta}-hyd roxyandrost-4-en-3-one).

[(40)] (xl) Mibolerone (7{alpha},17{alpha}-dimethyl-17 {beta}-hydroxyestr-4-en-3-one).

[(41)] (xli) 17{alpha}-methyl-{Delta} 1-dihydrotestosterone (17b{beta}-hydroxy-17{alpha}-methyl-5{alpha}-androst-1-en-3-one) (a.k.a. '17-{alpha}-methyl-1-testosterone').

[(42)] (xlii) Nandrolone(17{beta}-hydroxyestr-4-en-3-one).

[(43)] (xliii) 19-nor-4-androstenediol (3{beta},17{beta}-dihydro xyestr- 4-ene).

[(44)] (xliv) 19-nor-4-androstenediol (3{alpha},17{beta}-dihydroxyestr-4-ene).

[(45)] (xlv) 19-nor-5-androstenediol (3{beta},17{beta}-dihydroxyestr -5-ene).

[(46)] (xlvi) 19-nor-5-androstenediol (3{alpha},17{beta}-dihydroxyestr-5-ene).

[(47)] (xlvii) 19-nor-4,9(10)-androstadienedione (estra-4,9(10)-diene-3,17-dione).

[(48)] (xlviii) 19-nor-4-androstenedione (estr-4-en-3,17-dione).

[(49)] (xlix) 19-nor-5-androstenedione (estr-5-en-3,17-dione).

[(50)] (l) Norbolethone (13{beta}, 17{alpha}-diethyl-17 {beta} -hydroxygon-4-en-3-one).

[(51)] (li) Norclostebol (4-chloro-17{beta}-hydroxyestr-4- en-3-one).

[(52)] (lii) Norethandrolone (17{alpha}-ethyl-17{beta}-hydroxyestr-4-en-3-one).

[(53)] (liii) Normethandrolone (17 {alpha}-methyl-17{beta}-hydroxy estr-4-en-3-one).

[(54)] (liv) Oxandrolone (17{alpha}-methyl-17{beta}-hydroxy-2-oxa- {5{alpha}}-androstan-3-one).

[(55)] (lv) Oxymesterone (17{alpha}-methyl-4, 17 {beta}-dihydroxy androst-4-en-3-one).

[(56)] (lvi) Oxymetholone (17 {alpha}-methyl-2-hydroxymethylene-17 {beta}-hydroxy-{5{alpha}}- androstan-3-one).

[(57)] (lvii) Stanozolol (17{alpha}-methyl-17{beta}-hydroxy-{5 {alpha}}- androst-2-eno{3, 2-c}-pyrazole).

[(58)] (lviii) Stenbolone (17{beta}-hydroxy-2-methyl-{5{alpha}}-androst- 1-en-3-one).

[(59)] (lix) Testolactone (13-hydroxy-3-oxo-13, 17-secoandrosta-1, 4-dien-17-oic acid lactone).

[(60)] (lx) Testosterone (17{beta}-hydroxyandrost-4-en-3-one).

[(61)] (lxi) Tetrahydrogestrinone (13{beta}, 17{alpha} -diethyl-17{beta}-hydroxygon-4, 9, 11 -trien-3-one).

[(62)] (lxii) Trenbolone (17{beta}-hydroxyestr-4, 9, 11-trien- 3-one).

[(63)] (lxiii)5{alpha}-androstan-3,6,17-trione.

(lxiv) 6-bromo-androsta-1,4-diene-3,17-dione.

(lxv) 6-bromo-androstan-3,17-dione.

(lxvi) 4-chloro-17{alpha}-methyl-androsta-1,4-diene-3,17{beta}-diol.

(lxvii) 4-chloro-17{alpha}-methyl-androst-4-ene-3{beta},17{beta}-diol.

(lxviii) 4-chloro-17{alpha}-methyl-17{beta}hydroxy-androst-4-en-3-one.

(lxix) 4-chloro-17{alpha}-methyl-17{beta}hydroxy-androst-4-ene-3,11-di one.

(lxx) 2{alpha}, 17{alpha}-dimethyl-17{beta}-hydroxy-5{beta}-androstan-3 -one.

(lxxi) 2{alpha},3{alpha}-epithio-17{alpha}-methyl-5{alpha}androstan-17 {beta}-ol.

(lxxii) estra-4,9,11-triene-3,17-dione.

(lxxiii) [3,2-c]furazan-5{alpha}-androstan-17{beta}ol.

(lxxiv) 18a-homo-3-hydroxy-estra-2,5(10)-dien-17-one.

(lxxv) 4-hydroxy-androst-4-ene-3,17-dione.

(lxxvi) 17{beta}-hydroxy-androstano[2,3-d]isoxazole.

((lxxvii) 17{beta}-hydroxy-androstano[3,2-c]isoxazole.

(lxxviii) 3{beta}-hydroxy-estra-4,9,11-trien-17-one.

(lxxix) Methasterone (2{alpha},17{alpha}-dimethyl-5{alpha}-androstan- 7{beta}-ol-3-one)or 2{alpha}17{alpha}-dimethyl-17{beta}-hydroxy-5 {alpha}-androstan-3-one).

(lxxx) 17{alpha}-methyl-androsta-1,4-diene-3,17{beta}-diol.

(lxxxi) 17{alpha}-methyl-5{alpha}-androstan-17{beta}-ol.

(lxxxii) 17{alpha}-methyl-androstan-3-hydroxyimine-17{beta}-ol.

(lxxxiii) 6{alpha}-methyl-androst-4-ene-3,17-dione.

(lxxxiv) 17{alpha}-methyl-androst-2-ene-3,17{beta}diol.

(lxxxv) Prostanozol(17{beta}-hydroxy-5{alpha}-androstano[3,2-c]pyrazole) or[3,2-c]pyrazole-5{alpha}-androstan-17{beta}-ol.

(lxxxvi) [3,2-c]pyrazole-androst-4-en-17{beta}-ol.

(lxxxvii) Any salt, ester or ether of a drug or substance described or listed in this subdivision.

(2) (i) Subject to subparagraph (ii) of this paragraph, a drug or hormonal substance, other than estrogens, progestins, corticosteroids, and dehydroepiandrosterone, that is not listed in paragraph one of this subdivision and is derived from, or has a chemical structure substantially similar to, one or more anabolic steroids listed in paragraph one of this subdivision shall be considered to be an anabolic steroid for purposes of this schedule if:

(A) the drug or substance has been created or manufactured with the intent of producing a drug or other substance that either:

1. promotes muscle growth; or

2. otherwise causes a pharmacological effect similar to that of testosterone; or

(B) the drug or substance has been, or is intended to be, marketed or otherwise promoted in any manner suggesting that consuming it will promote muscle growth or any other pharmacological effect similar to that of testosterone.

(ii) A substance shall not be considered to be a drug or hormonal substance for purposes of this subdivision if:

(A) it is:

1. an herb or other botanical;

2. a concentrate, metabolite, or extract of, or a constituent isolated directly from, an herb or other botanical; or

3. a combination of two or more substances described in clause one or two of this item;

(B) it is a dietary ingredient for purposes of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.); and

(C) it is not anabolic or androgenic.

(iii) In accordance with subdivision one of section thirty-three hundred ninety-six of this article, any person claiming the benefit of an exemption or exception under subparagraph (ii) of this paragraph shall bear the burden of going forward with the evidence with respect to such exemption or exception.

§ 17. Subdivision (c) of schedule III of section 3306 of the public health law is amended by adding two new paragraphs 15 and 16 to read as follows:

(15) Perampanel.

(16) Xylazine, its salts, isomers and salts of isomers.

§ 18. Subdivision (c) of schedule IV of section 3306 of the public health law is amended by adding seven new paragraphs 54, 55, 56, 57, 58, 59 and 60 to read as follows:

(54) Alfaxalone.

(55) Brexanolone.

(56) Daridorexant.

(57) Lemborexant.

(58) Remimazolam.

(59) Suvorexant.

(60) Zuranolone.

§ 19. Subdivision (e) of schedule IV of section 3306 of the public health law is amended by adding two new paragraphs 13 and 14 to read as follows:

(13) Serdexmethylphenidate.

(14) Solriamfetol.

§ 20. Subdivision (f) of schedule IV of section 3306 of the public health law, as added by chapter 664 of the laws of 1985, paragraph 2 as added by chapter 457 of the laws of 2006 and paragraph 3 as added by section 14 of part C of chapter 447 of the laws of 2012, is amended to read as follows:

(f) Other substances. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture or preparation which contains any quantity of the following substances, including its salts, isomers, and salts of such isomers, whenever the existence of such salts, isomers, and salts of isomers is possible:

(1) Pentazocine.

(2) Butorphanol (including its optical isomers).

(3) Tramadol in any quantities.

(4) Eluxadoline. (5-{{{(2S)-2-amino-3-{4-aminocarbonyl)-2,6-dimethyl phenyl}-1-oxopropyl}{(1S)-1-(4-phenyl-1H-imidazol-2-yl)ethyl}amino}methyl}-2-methoxybenzoic acid).

(5) Lorcaserin.

§ 21. Subdivision (d) of schedule V of section 3306 of the public health law is amended by adding four new paragraphs 4, 5, 6 and 7 to read as follows:

(4) Brivaracetam ((2S)-2-{(4R)-2-oxo-4-propylpyrrolidin-1-yl} butanamide). Some trade or other names: BRV; UCB-34714; Briviact) (including its salts).

(5) Cenobamate ({1R)-1-(2-chlorophenyl)-2-(tetrazol-2-yl)ethyl} carbamate; 2H-tetrazole-2-ethanol, alpha-(2-chlorophenyl)-, carbamate

(ester), (alphaR)-; carbamic acid
(R)-(+)-1-(2-chlorophenyl)-2-(2H-tetrazol-2-yl)ethyl ester).

(6) Ganaxolone. 3@-hydroxy-3&-methyl-5@-pregnan-20-one.

(7) Lasmiditan
{2,4,6-trifluoro-N-(6-(1-methylpiperidine-4-carbonyl)pyridine-2-yl-benzamide}.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Controlled substances may be ordered for use by [an addict] a person with a substance use disorder or habitual user by a practitioner and administered by a practitioner [or], registered nurse, or paramedic to relieve acute withdrawal symptoms.

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

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

5. [Methadone] Notwithstanding any other law and consistent with federal requirements, methadone, or such other controlled substance

designated by the commissioner as appropriate for such use, may be administered or dispensed directly to [an addict] a person with a substance use disorder by a practitioner or by [his] their designated agent acting under the direction and supervision of a practitioner, as part of a substance [abuse or chemical dependence] use disorder program approved pursuant to article [twenty-three or] thirty-two of the mental hygiene law.

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

§ 29. This act shall take effect immediately.

PART V

Section 1. Section 2805-x of the public health law, as added by section 48 of part B of chapter 57 of the laws of 2015, paragraph (d) of subdivision 4 as added by chapter 697 of the laws of 2023, is amended to read as follows:

§ 2805-x. [Hospital-home care-physician] Health care delivery collaboration program. 1. The purpose of this section shall be to facilitate innovation in [hospital, home care agency and physician collaboration in meeting] collaborations between licensed and certified health care providers and agencies, including: hospitals, home care agencies, emergency medical services, skilled nursing facilities, and hospices, as well as payors and other interdisciplinary providers, practitioners and service entities, to meet the community's evolving health care needs in a changing health care delivery landscape. It shall provide a framework to support voluntary initiatives in collaboration to improve patient care access and management, patient health outcomes, cost-effectiveness in the use of health care services and community population health.

[Such collaborative initiatives may also include payors, skilled nursing facilities and other interdisciplinary providers, practitioners and service entities.]

2. For purposes of this section:

(a) "Hospital" shall include a general hospital as defined in this article or other inpatient facility for rehabilitation or specialty care within the definition of hospital in this article.

(b) "Home care agency" shall mean a certified home health agency, long term home health care program or licensed home care services agency as defined in article thirty-six of this chapter.

(c) "Payor" shall mean a health plan approved pursuant to article forty-four of this chapter, or article thirty-two or forty-three of the insurance law.

(d) "Practitioner" shall mean any of the health, mental health or health related professions licensed pursuant to title eight of the education law.

(e) "Physician" shall mean a person duly licensed pursuant to article one hundred thirty-one of the education law.

(f) "Hospice" shall mean an agency approved under article forty of this chapter.

(g) "Emergency medical services" shall mean an agency approved under article thirty of this chapter and authorized pursuant to section three thousand eighteen of this chapter to provide community paramedicine.

(h) "Skilled nursing facility" shall mean a residential health care facility or nursing home licensed pursuant to article twenty-eight of this chapter.

3. The commissioner is authorized to provide financing including, but not limited to, grants or positive adjustments in medical assistance

rates or premium payments, to the extent of funds available and allocated or appropriated therefor, including funds provided to the state through federal waivers, funds made available through state appropriations and/or funding through section twenty-eight hundred seven-v of this article, as well as waivers of regulations under title ten of the New York codes, rules and regulations, to support the voluntary initiatives and objectives of this section.

4. [Hospital-home care-physician] Health care delivery collaborative initiatives under this section may include, but shall not be limited to:

(a) [Hospital-home care-physician integration] Integration initiatives between at least two of the following: hospitals, home care agencies, physician, physicians' group, emergency medical services, hospice, and skilled nursing facilities, including but not limited to:

(i) transitions in care initiatives to help effectively transition patients to post-acute care at home, coordinate follow-up care and address issues critical to care plan success and readmission avoidance;

(ii) clinical pathways for specified conditions, guiding patients' progress and outcome goals, as well as effective health services use;

(iii) application of telehealth/telemedicine services in monitoring and managing patient conditions, and promoting self-care/management, improved outcomes and effective services use;

(iv) facilitation of physician house calls to homebound patients and/or to patients for whom such home visits are determined necessary and effective for patient care management;

(v) additional models for prevention of avoidable hospital readmissions and emergency room visits;

(vi) health home development;

(vii) development and demonstration of new models of integrated or collaborative care and care management not otherwise achievable through existing models; and

(viii) bundled payment demonstrations for hospital-to-post-acute-care for specified conditions or categories of conditions, in particular, conditions predisposed to high prevalence of readmission, including those currently subject to federal/state penalty, and other discharges with extensive post-acute needs;

(b) Recruitment, training and retention of hospital/home care direct care staff and physicians, in geographic or clinical areas of demonstrated need. Such initiatives may include, but are not limited to, the following activities:

(i) outreach and public education about the need and value of service in health occupations;

(ii) training/continuing education and regulatory facilitation for cross-training to maximize flexibility in the utilization of staff, including:

(A) training of hospital nurses in home care;

(B) dual certified nurse aide/home health aide certification; and

(C) dual personal care aide/HHA certification;

(iii) salary/benefit enhancement;

(iv) career ladder development; and

(v) other incentives to practice in shortage areas; and

(c) [Hospital - home care - physician] <u>Health care delivery</u> collaboratives for the care and management of special needs, high-risk and high-cost patients, including but not limited to best practices, and training and education of direct care practitioners and service employees.

(d) Collaborative programs to address disparities in health care access or treatment, and/or conditions of higher prevalence, in certain populations, where such collaborative programs could provide and manage services in a more effective, person-centered and cost-efficient manner for reduction or elimination of such disparities.

(i) Such programs may target one or more disparate conditions, or areas of under-service, evidenced in defined populations, including but not be limited to:

(A) cardiovascular disease;

(B) hypertension;

(C) diabetes;

(D) chronic kidney disease;

(E) obesity;

(F) asthma;

(G) sickle cell disease;

(H) sepsis;

(I) lupus;

(J) breast, lung, prostate and colorectal cancers;

(K) geographic shortage of primary care, prenatal/obstetric care, specialty medical care, home health care, or culturally and linguistically compatible care;

(L) alcohol, tobacco, or substance abuse;

(M) post-traumatic stress disorder and other conditions more prevalent among veterans of the United States military services;

(N) attracting members of minority populations to the field and practice of medicine; and

(O) such other areas approved by the commissioner.

(ii) Collaborative [hospital-home care-physician] health care delivery, and as applicable additional partner, models may include under such disparities programs:

(A) service planning and design;

(B) recruitment of specialty personnel and/or specialty training of professionals or other direct care personnel (including physicians, home care and hospital staffs), patients and informal caregivers;

(C) continuing medical education and clinical training for physicians, follow-up evaluations, and supporting educational materials;

(D) use of evidenced-based approaches and/or best practices to treatment;

(E) reimbursement of uncovered services;

(F) bundled or other integrated payment methods to support the necessary, coordinated and cost-effective services;

(G) regulatory waivers to facilitate flexibility in provider collaboration and person-centered care;

(H) patient/family peer support and education;

(I) data collection, research and evaluation of efficacy; and/or

(J) other components or innovations satisfactory to the commissioner.

(iii) Nothing contained in this paragraph shall prevent a physician, [physicians] physicians' group, home care agency, or hospital from individually applying for said grant.

(iv) The commissioner shall consult with physicians, home care agencies, hospitals, consumers, statewide associations representative of such participants, and other experts in health care disparities, in developing an application process for grant funding or rate adjustment, and for request of state regulatory waivers, to facilitate implementation of disparities programs under this paragraph.

5. At a minimum, applications for collaborative initiatives under this section must specifically identify the service gaps and/or community need the collaboration seeks to address, and outline a projected timeline for implementation and deliverable data to demonstrate milestones to success.

6. Hospitals and home care agencies which are provided financing or waivers pursuant to this section shall report to the commissioner on the patient, service and cost experiences pursuant to this section, including the extent to which the project goals are achieved. The commissioner shall compile and make such reports available on the department's website.

§ 2. Subdivision 2 of section 3602 of the public health law, as added by chapter 895 of the laws of 1977, is amended to read as follows:

2. "Home care services agency" means an organization primarily engaged in arranging and/or providing directly or through contract arrangement one or more of the following: Nursing services, home health aide services, and other therapeutic and related services which may include, but shall not be limited to, physical, speech and occupational therapy, nutritional services, medical social services, personal care services, homemaker services, and housekeeper or chore services, which may be of a preventive, therapeutic, rehabilitative, health guidance, and/or supportive nature to persons at home. For the purposes of this article, a general hospital licensed pursuant to article twenty-eight of this chapter shall not be considered "primarily engaged in arranging and/or providing" nursing, home health, or other therapeutic services notwithstanding that such services may be provided in a patient's residence, provided that at least fifty-one percent of patient care hours for such general hospital is generated from the treatment of patients within the

hospital, and that any patients treated in their residence have a preexisting clinical relationship with the general hospital.

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

15. Notwithstanding any contrary provision of this article, or any rule or regulation to the contrary, the commissioner shall allow general hospitals to provide off-site primary care and medical care services, including but not limited to acute care and preventative wellness care, that are:

(a) not home care services defined in subdivision one of section thirty-six hundred two of this chapter or the professional services enumerated in subdivision two of such section;

(b) provided by a primary care professional, including a physician, registered nurse, or physician assistant, to a patient with a pre-existing clinical relationship with the general hospital, or with the health care professional providing the service; and

(c) provided to a patient who is unable to leave his or her residence to receive services at the general hospital without unreasonable difficulty due to circumstances, including but not limited to, clinical impairment and conditions of immunosuppression.

(d) Nothing in this subdivision shall preclude a federally qualified health center from providing off-site services in accordance with department regulations.

(e) The department is authorized to establish medical assistance program rates to effectuate this subdivision. For the purposes of the department determining the applicable rates pursuant to such authority, any general hospital approved pursuant to this subdivision shall report to the department, in the form and format required by the department,

its annual operating costs, specifically for such off-site acute services. Failure to timely submit such cost data to the department may result in revocation of authority to participate in a program under this section due to the inability to establish appropriate reimbursement rates.

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

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

(b) Any program not lawfully operating and established pursuant to paragraph (a) of this subdivision may apply to the department for approval to operate a mobile integrated and community paramedicine program, and any program currently operating pursuant to paragraph (a) of this subdivision for a limited purpose, including but not limited to vaccination administration, may apply to the department for approval to modify its existing community paramedicine program. The department may approve up to two hundred new or expanded programs pursuant to this paragraph. Such applications must be submitted in the form and format prescribed by the department. Programs approved pursuant to this paragraph shall be permitted to operate through March thirty-first, two thousand thirty-one.

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

§ 2. This act shall take effect immediately and shall expire and be deemed repealed [2 years after such date] March 31, 2031; provided, however, that if this act shall have become a law on or after May 22, 2023 this act shall take effect immediately and shall be deemed to have been in full force and effect on and after May 22, 2023.

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

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

§ 7. Section 6909 of the education law is amended by adding a new subdivision 12 to read as follows:

12. A certified nurse practitioner may prescribe and order a non-patient specific regimen to an emergency medical services practitioner licensed by the department of health pursuant to article thirty of the public health law, pursuant to regulations promulgated by the commissioner, and consistent with the public health law, for administering

immunizations. Nothing in this subdivision shall authorize unlicensed persons to administer immunizations, vaccines or other drugs.

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

12. A licensed physician may prescribe and order a non-patient specific regimen to an emergency medical services practitioner licensed by the department of health pursuant to article thirty of the public health law, pursuant to regulations promulgated by the commissioner, and consistent with the public health law, for administering immunizations. Nothing in this subdivision shall authorize unlicensed persons to administer immunizations, vaccines or other drugs.

§ 9. The public health law is amended by adding a new article 30-D to read as follows:

ARTICLE 30-D

EMERGENCY MEDICAL SERVICES ESSENTIAL SERVICES ACT

§ 3080. Declaration of purpose. 1. The provision of prompt, efficient, and effective emergency medical services and emergency medical dispatch is crucial to the health and safety of the residents of New York state.

2. The establishment of a comprehensive and standardized system for medical emergency response is essential to address life-threatening

conditions and ensure the well-being of individuals in need of urgent medical care.

3. Ensuring that every county within New York state has the necessary resources, trained personnel, and operational capabilities to provide medical emergency response is a matter of public interest and state priority.

4. It is imperative to standardize the approach to medical emergency response and dispatch services to enhance the quality of care, maximize efficiency, and improve outcomes for patients experiencing medical emergencies.

5. The designation of medical emergency response and emergency medical dispatch as essential services will ensure a uniform, effective, and coordinated response to medical emergencies across the state.

6. This article aims to establish a framework for the provision, operation, and regulation of medical emergency response and dispatch services, thereby safeguarding the health and safety of New York state's residents and visitors.

§ 3081. Application of article. This article shall apply to every county except a county wholly contained within a city.

§ 3082. Definitions. As used in this article, the following terms shall have the following meanings:

1. "Medical emergency response" shall mean the rapid deployment of ambulance services, advanced life support first response services, and other first response services authorized by the department to provide emergency medical services, as defined in section three thousand one of this chapter, for the purpose of providing immediate emergency medical care in response to emergency calls for acute conditions where rapid intervention is vital to prevent death or serious harm.

2. "Emergency medical dispatch" means a protocol-driven system approved by the department designed to manage, assess, and prioritize medical emergency calls, provide critical pre-arrival instructions, and dispatch medical emergency response services or provide referral to appropriate non-emergency medical services where appropriate.

3. "EMS medical dispatch agency" means any individual, partnership, association, corporation, municipality or any legal or public entity or subdivision thereof licensed by the department who is engaged in receiving requests for emergency medical assistance from the public and dispatching medical emergency response services as needed.

4. "Medical emergency readiness assessment" means the rating system evaluating the preparedness, efficiency, and effectiveness of medical emergency response within a community.

§ 3083. Designation of medical emergency response and emergency medical dispatch agencies as essential services. 1. Medical emergency response and emergency medical dispatch agencies are hereby declared essential services within New York state.

2. Every county, acting individually or jointly with any other county, city, town, and village, shall ensure that an emergency medical service, ambulance service, advanced life support first response service, other first response services authorized by the department to provide emergency medical services, or a combination of such services are provided for the purposes of effectuating medical emergency response within the boundaries of the county.

3. Every county acting individually or jointly with any other county, city, town, and village, shall develop, implement, and maintain a comprehensive county medical emergency response plan, in a format approved by the department, ensuring the effective operation, coordi-

nation, and funding of medical emergency response. In furtherance of that purpose, the county shall designate one or more primary medical emergency response agencies that shall respond to all calls and demands for such medical emergency response to persons entitled thereto, subject to any limitations upon such service specified in an agreement, within the boundaries of the county. No medical emergency response agency, designated by the county in the plan, may refuse to respond to a request for service unless they can prove, to the satisfaction of the department, that they are unable to respond because of capacity limitations.

4. Notwithstanding the provisions of section three thousand eight of this chapter, any county acting individually or jointly with any other county, city, town, and village, that provides, either directly or through agreement with existing services, an emergency medical service or general ambulance service in accordance with section one hundred twenty-two-b of the general municipal law, for the purpose of effectuating medical emergency response, upon meeting or exceeding all administrative and operational standards set by the department, and upon filing written notice to the department in a manner prescribed by the department, shall be deemed to have satisfied any and all requirements for determination of public need for the establishment of additional emergency medical services and the department shall issue a non-transferable, permanent municipal ambulance service operating certificate. Nothing in this article shall be deemed to exclude any county issued a municipal ambulance service operating certificate from complying with any other requirement of article thirty of this chapter or any other applicable provision of law or regulations promulgated thereunder.

5. Any county acting individually or jointly with any other county, city, town, and village, that provides, either directly or through

agreement with an existing service, an emergency medical service or general ambulance service in accordance with section one hundred twenty-two-b of the general municipal law, for the purpose of effectuating medical emergency response may establish a special district, after ninety days notice to the department, as defined in subdivision sixteen of section one hundred two of the real property tax law, for the financing and operation of such emergency medical service or general ambulance service in accordance with section one hundred twenty-two-b of the general municipal law with an emergency medical services agency licensed by the department to provide emergency medical services in the state. Such special district shall be exempt from the provisions of section three-c of the general municipal law until five years after the establishment of the special district.

6. The department shall establish standards, with the advice from the state emergency medical services council, the state emergency medical advisory committee and the state trauma advisory committee, establishing minimum standards for the provision of emergency medical services by first aid squads, basic life support first response services, special event medical services, and other first response services not otherwise defined in article thirty of this chapter.

§ 3084. Provision of emergency medical dispatch. 1. Every emergency medical dispatch agency operating within New York state shall provide emergency medical dispatch services in accordance with protocols approved by the department.

2. All emergency medical dispatch agencies shall be licensed by the department. The department shall establish criteria for the licensing of emergency medical dispatch agencies to ensure compliance with emergency medical dispatch standards.

3. All emergency medical dispatchers employed by emergency medical dispatch agencies must complete a certification training course approved by the department and maintain continuous certification while employed by the emergency medical dispatch agency as an emergency medical dispatcher. The department shall establish minimum standards for emergency medical dispatch training courses and dispatcher certification.

§ 3085. Rules and regulations. The commissioner may promulgate rules and regulations to effectuate the purposes of this article.

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

§ 3019. Emergency medical services demonstration programs. 1. The purpose of this section shall be to facilitate innovation in medical care provided by emergency medical service practitioners in meeting the community's health care needs, including collaboration with other health care organizations operating under the provisions of section twenty-eight hundred five-x of this chapter. It shall provide a framework to support voluntary initiatives to improve patient care access and management, patient health outcomes, and cost-effectiveness in the use of health care services and community population health.

2. The commissioner is authorized to provide financing including, to the extent of funds available and allocated or appropriated therefor, as well as waivers of certain parts of this article, article thirty-A of this chapter, and regulations under title ten of the New York codes, rules and regulations, to support the voluntary initiatives and objectives of this section.

§ 11. The public health law is amended by adding a new section 3055 to read as follows:

§ 3055. EMS licensure and credentialing. 1. The department, with the approval of the state emergency medical services council, may establish minimum standards for the licensure of emergency medical services practitioners including but not limited to emergency medical technicians and advanced emergency medical technicians by the department.

2. The department, with the approval of the state emergency medical services council, may establish minimum standards for specialized credentialing of emergency medical service practitioners which shall include, but not be limited to, emergency vehicle operator, critical care paramedic, emergency medical dispatcher, emergency medical services field training officer, emergency medical services administrator, emergency medical control physician, and emergency medical services agency medical director.

§ 12. The public health law is amended by adding a new section 3029 to read as follows:

§ 3029. Paramedic urgent care program. 1. The department shall establish a paramedic urgent care program to evaluate the role of emergency medical services personnel in the delivery of health care services in rural counties of New York state.

2. Any organization that is authorized to provide advanced life support services, in accordance with section three thousand thirty of this article, may apply to the department for approval to operate a paramedic urgent care.

3. Any paramedic urgent care programs approved by the department under this section shall: (a) be under the overall supervision and direction of a qualified physician; (b) be staffed by qualified medical and health personnel, physician assistants, or nurse practitioners; (c) utilize advanced emergency medical technicians whose scope of practice is appro-

priate for the medical services provided; (d) maintain a treatment-management record for each patient; and (e) be integrated with a hospital or other appropriate healthcare organization.

4. Paramedic urgent care programs may integrate telehealth provided by a telehealth provider, as those terms are defined in section twenty-nine hundred ninety-nine-cc of this chapter. The commissioner may specify in regulation additional acceptable modalities for the delivery of health care services by paramedic care programs via telehealth, including but not limited to audio-only or video-only telephone communications, online portals and survey applications.

5. Nothing in this section shall be deemed to allow a person to provide any service for which a license, registration, certification or other authorization under title eight of the education law is required and which the person does not possess, provided that any service being excluded pursuant to this subdivision shall not include a service that is within the scope of practice for the respective emergency medical services personnel.

§ 13. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2024; provided, however, that the amendments to subdivision 3 of section 3018 of the public health law made by section four of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART W

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

§ 226. Interagency elder justice coordinating council. 1. There is hereby created within the office an elder justice coordinating council consisting of representatives of state agencies whose work involves elder justice to create greater collaboration and develop overarching strategies, systems, and programs to be carried out in accordance with the governor's elder justice priorities, with a goal of protecting older adults from abuse and mistreatment. The council shall collaborate to identify and support consistent policies and program operation, facilitate communication among state agencies, foster collaborative relationships, and help state agencies keep informed of local, state, and national developments in elder justice.

2. The council shall be chaired by the director of the office for the aging, and shall include representation from the office of victims services, the office of children and family services, the department of financial services, the division of criminal justice services, the office of mental health, the office for the prevention of domestic violence, the department of health, the office for people with developmental disabilities, the New York state police, the justice center for the protection of people with special needs, and the department of state's division of consumer protection. Additionally, the council shall request input from stakeholders, advocates, experts, and coalitions.

3. The council shall:

(a) develop and implement a cohesive, comprehensive state plan on elder justice that aligns state elder justice policy and programs across state agency responsibilities;

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

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

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

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

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

4. Each member agency shall maintain control over, and responsibility for, its own programs and policies. The council shall not take the place of any existing interagency councils and committees. The council shall serve to focus attention on elder justice comprehensively and create a multidisciplinary mechanism to work toward alignment across agencies to help achieve the governor's elder justice priorities.

5. The council shall meet regularly and shall submit a report on its activities to the governor and the legislature no later than December thirty-first, two thousand twenty-five and annually thereafter.

§ 2. This act shall take effect immediately.

PART X

Section 1. Section 5 of part NN of chapter 57 of laws of 2018 amending the public health law and other laws relating to the opioid stewardship act, as amended by section 5 of part XX of chapter 59 of the laws of 2019, is amended to read as follows:

§ 5. This act shall take effect July 1, 2018 and sections one, two and four of this part shall expire and be deemed to be repealed on June 30, 2024, provided that, effective immediately, the addition, amendment

and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date, and, provided that this act shall only apply to the sale or distribution of opioids in the state of New York on or before December 31, 2018.

§ 2. This act shall take effect immediately.

PART Y

Section 1. Section 7 of part R2 of chapter 62 of the laws of 2003, amending the mental hygiene law and the state finance law relating to the community mental health support and workforce reinvestment program, the membership of subcommittees for mental health of community services boards and the duties of such subcommittees and creating the community mental health and workforce reinvestment account, as amended by section 1 of part W of chapter 57 of the laws of 2021, is amended to read as follows:

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

§ 2. This act shall take effect immediately.

PART Z

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

of part V of chapter 57 of the laws of 2021, is amended to read as follows:

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

§ 2. This act shall take effect immediately.

PART AA

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

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

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

(K) This subparagraph shall apply to outpatient treatment provided in a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law, or in a facility operated by the office of mental health, or in a crisis stabilization center licensed pursuant to section 36.01 of the mental hygiene law, that is participating in the insurer's

provider network. Reimbursement for covered outpatient treatment provided by such a facility shall be at a rate that is not less than the rate that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law.

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

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

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

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

to the medical assistance program under title eleven of article five of the social services law.

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

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

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

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

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

PART BB

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

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

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

§ 2. This act shall take effect immediately.

PART CC

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

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

§ 2. This act shall take effect immediately.

PART DD

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

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

§ 2. This act shall take effect immediately.

PART EE

Section 1. Subparagraph (v) of paragraph (a) of subdivision 1 of section 6908 of the education law is renumbered subparagraph (vi) and a new subparagraph (v) is added to read as follows:

(v) tasks provided by a direct support staff in non-facility based programs certified, authorized or approved by the office for people with developmental disabilities, so long as such staff does not hold themself out as one who accepts employment solely for performing such care, and where nursing services are under the instruction of a service recipient or family or household member determined by a registered professional nurse to be capable of providing such instruction. In the event that the registered nurse determines that the service recipient, family, or household member is not capable of providing such instruction, nursing tasks may be performed by direct support staff pursuant to subparagraph (vi) of this paragraph subject to the requirements set forth therein; or

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

PART FF

Section 1. 1. Subject to available appropriations and approval of the director of the budget, the commissioners of the office of mental health, office for people with developmental disabilities, office of addiction services and supports, office of temporary and disability assistance, office of children and family services, and the state office for the aging shall establish a state fiscal year 2024-2025 cost of living adjustment (COLA), effective April 1, 2024, for projecting for the effects of inflation upon rates of payments, contracts, or any other form of reimbursement for the programs and services listed in paragraphs

(i), (ii), (iii), (iv), (v), and (vi) of subdivision four of this section. The COLA established herein shall be applied to the appropriate portion of reimbursable costs or contract amounts. Where appropriate, transfers to the department of health (DOH) shall be made as reimbursement for the state share of medical assistance.

2. Notwithstanding any inconsistent provision of law, subject to the approval of the director of the budget and available appropriations therefore, for the period of April 1, 2024 through March 31, 2025, the commissioners shall provide funding to support a one and five-tenths percent (1.5%) cost of living adjustment under this section for all eligible programs and services as determined pursuant to subdivision four of this section.

3. Notwithstanding any inconsistent provision of law, and as approved by the director of the budget, the 1.5 percent cost of living adjustment (COLA) established herein shall be inclusive of all other cost of living type increases, inflation factors, or trend factors that are newly applied effective April 1, 2024. Except for the 1.5 percent cost of living adjustment (COLA) established herein, for the period commencing on April 1, 2024 and ending March 31, 2025 the commissioners shall not apply any other new cost of living adjustments for the purpose of establishing rates of payments, contracts or any other form of reimbursement. The phrase "all other cost of living type increases, inflation factors, or trend factors" as defined in this subdivision shall not include payments made pursuant to the American Rescue Plan Act or other federal relief programs related to the Coronavirus Disease 2019 (COVID-19) pandemic public health emergency. This subdivision shall not prevent the office of children and family services from applying additional trend

factors or staff retention factors to eligible programs and services under paragraph (v) of subdivision four of this section.

4. Eligible programs and services. (i) Programs and services funded, licensed, or certified by the office of mental health (OMH) eligible for the cost of living adjustment established herein, pending federal approval where applicable, include: office of mental health licensed outpatient programs, pursuant to parts 587 and 599 of title 14 CRR-NY of the office of mental health regulations including clinic, continuing day treatment, day treatment, intensive outpatient programs and partial hospitalization; outreach; crisis residence; crisis stabilization, crisis/respite beds; mobile crisis, part 590 comprehensive psychiatric emergency program services; crisis intervention; home based crisis intervention; family care; supported single room occupancy; supported housing; supported housing community services; treatment congregate; supported congregate; community residence - children and youth; treatment/apartment; supported apartment; community residence single room occupancy; on-site rehabilitation; employment programs; recreation; respite care; transportation; psychosocial club; assertive community treatment; case management; care coordination, including health home plus services; local government unit administration; monitoring and evaluation; children and youth vocational services; single point of access; school-based mental health program; family support children and youth; advocacy/support services; drop in centers; recovery centers; transition management services; bridger; home and community based waiver services; behavioral health waiver services authorized pursuant to the section 1115 MRT waiver; self-help programs; consumer service dollars; conference of local mental hygiene directors; multicultural initiative; ongoing integrated supported employment services; supported education;

mentally ill/chemical abuse (MICA) network; personalized recovery oriented services; children and family treatment and support services; residential treatment facilities operating pursuant to part 584 of title 14-NYCRR; geriatric demonstration programs; community-based mental health family treatment and support; coordinated children's service initiative; homeless services; and promises zone.

(ii) Programs and services funded, licensed, or certified by the office for people with developmental disabilities (OPWDD) eligible for the cost of living adjustment established herein, pending federal approval where applicable, include: local/unified services; chapter 620 services; voluntary operated community residential services; article 16 clinics; day treatment services; family support services; 100% day training; epilepsy services; traumatic brain injury services; hepatitis B services; independent practitioner services for individuals with intellectual and/or developmental disabilities; crisis services for individuals with intellectual and/or developmental disabilities; family care residential habilitation; supervised residential habilitation; supportive residential habilitation; respite; day habilitation; prevocational services; supported employment; community habilitation; intermediate care facility day and residential services; specialty hospital; pathways to employment; intensive behavioral services; basic home and community based services (HCBS) plan support; community transition services; family education and training; fiscal intermediary; support broker; and personal resource accounts.

(iii) Programs and services funded, licensed, or certified by the office of addiction services and supports (OASAS) eligible for the cost of living adjustment established herein, pending federal approval where applicable, include: medically supervised withdrawal services - residen-

tial; medically supervised withdrawal services - outpatient; medically managed detoxification; medically monitored withdrawal; inpatient rehabilitation services; outpatient opioid treatment; residential opioid treatment; KEEP units outpatient; residential opioid treatment to abstinence; problem gambling treatment; medically supervised outpatient; outpatient rehabilitation; specialized services substance abuse programs; home and community based waiver services pursuant to subdivision 9 of section 366 of the social services law; children and family treatment and support services; continuum of care rental assistance case management; NY/NY III post-treatment housing; NY/NY III housing for persons at risk for homelessness; permanent supported housing; youth clubhouse; recovery community centers; recovery community organizing initiative; residential rehabilitation services for youth (RRSY); intensive residential; community residential; supportive living; residential services; job placement initiative; case management; family support navigator; local government unit administration; peer engagement; vocational rehabilitation; support services; HIV early intervention services; dual diagnosis coordinator; problem gambling resource centers; problem gambling prevention; prevention resource centers; primary prevention services; other prevention services; and community services.

(iv) Programs and services funded, licensed, or certified by the office of temporary and disability assistance (OTDA) eligible for the cost of living adjustment established herein, pending federal approval where applicable, include: nutrition outreach and education program (NOEP).

(v) Programs and services funded, licensed, or certified by the office of children and family services (OCFS) eligible for the cost of living adjustment established herein, pending federal approval where applica-

ble, include: programs for which the office of children and family services establishes maximum state aid rates pursuant to section 398-a of the social services law and section 4003 of the education law; emergency foster homes; foster family boarding homes and therapeutic foster homes; supervised settings as defined by subdivision twenty-two of section 371 of the social services law; adoptive parents receiving adoption subsidy pursuant to section 453 of the social services law; and congregate and scattered supportive housing programs and supportive services provided under the NY/NY III supportive housing agreement to young adults leaving or having recently left foster care.

(vi) Programs and services funded, licensed, or certified by the state office for the aging (SOFA) eligible for the cost of living adjustment established herein, pending federal approval where applicable, include: community services for the elderly; expanded in-home services for the elderly; and supplemental nutrition assistance program.

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

6. Notwithstanding any inconsistent provision of law to the contrary, agency commissioners shall be authorized to recoup funding from a local governmental unit or direct contract provider for the cost of living adjustment established herein determined to have been used in a manner

inconsistent with the appropriation, or any other provision of this section. Such agency commissioners shall be authorized to employ any legal mechanism to recoup such funds, including an offset of other funds that are owed to such local governmental unit or direct contract provider.

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

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

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