FY 2022 NEW YORK STATE EXECUTIVE BUDGET

HEALTH AND MENTAL HYGIENE
ARTICLE VII LEGISLATION

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Legislative Bill Drafting Commission
12571-01-1

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 2021-2022 state fiscal year)

BUDGBI. HMH Governor

AN ACT

to amend part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to known and projected department of health state fund Medicaid expenditures, in relation to extending the Medicaid global cap (Part A); to amend the social services law, in relation to copayments for drugs; to amend the public health law, in relation to prescriber prevails; and

IN SENATE_____

Senate introducer's signature

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

s15 Addabbo	s17 Felder	s07 Kaplan	s58 O'Mara	s10 Sanders
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IN ASSEMBLY_____

Assembly introducer's signature

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

a049 Abbate	a063 Cusick	a021 Griffin	a051 Mitaynes	a111 Santabarbara
a092 Abinanti	a045 Cymbrowitz	a100 Gunther	a015 Montesano	a090 Sayegh
a031 Anderson	a018 Darling	a139 Hawley	a145 Morinello	a099 Schmitt
a122 Angelino	a053 Davila	a083 Heastie	a065 Niou	a076 Seawright
a107 Ashby	a072 De La Rosa	a028 Hevesi	a037 Nolan	a084 Septimo
a035 Aubry	a003 DeStefano	a128 Hunter	a144 Norris	a016 Sillitti
a120 Barclay	a070 Dickens	a029 Hyndman	a069 O'Donnell	a052 Simon
a030 Barnwell	a054 Dilan	a079 Jackson	a091 Otis	a114 Simpson
a106 Barrett	a081 Dinowitz	a104 Jacobson	a132 Palmesano	a005 Smith
a060 Barron	a147 DiPietro	a011 Jean-Pierre	a088 Paulin	a118 Smullen
a082 Benedetto	a009 Durso	a134 Jensen	a141 Peoples-Stokes	a022 Solages
a042 Bichotte Hermelyn	a048 Eichenstein	a115 Jones		a057 Souffrant Forrest
	a004 Englebright	a077 Joyner	a058 Perry	
a117 Blankenbush	a074 Epstein	a125 Kelles	a023 Pheffer Amato	a110 Steck
a098 Brabenec	a109 Fahy	a040 Kim		a010 Stern
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a138 Bronson	a080 Fernandez	a013 Lavine	a089 Pretlow	a102 Tague
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a039 Cruz	a075 Gottfried	a020 Miller, M.	a121 Salka	a056 Zinerman

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).

LBDC 01/07/21

to repeal certain provisions of the social services law relating to coverage for certain prescription drugs (Part B); to amend the public health law, in relation to community health centers (Part C); to amend the public health law, in relation to reducing the hospital capital rate add-on (Part D); to amend the public health law, in relation to adjusting the worker recruitment and retention funding (Part E); to amend the public health law, the education law and the insurance law, in relation to comprehensive telehealth reforms (Part F); to amend the public health law, in relation to authorizing the implementation of medical respite pilot programs (Part G); to amend the social services law, in relation to eliminating consumer-paid premium payments in the basic health program (Part H); to amend the public health law, in relation to federal waiver authorization for the NY State of Health, the official Health Plan Marketplace (Part I); to amend the insurance law, in relation to the licensing of pharmacy benefit managers (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 restructuring and extending the physicians medical malpractice program; to amend part J of chapter 63 of the laws of 2001 amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, relating to the effectiveness of certain provisions of such chapter, in relation to extending certain provisions concerning the hospital excess liability pool; and to amend part H of chapter 57 of the laws of 2017, amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions relating thereto, in relation to extending provisions relating to excess coverage (Part K); to amend the public health law,

in relation to the general public health work program (Part L); to amend the public health law, the state finance law, chapter 338 of the laws of 1998 amending the public health law, the public officers law and the state finance law relating to establishing a spinal cord injury research board and part H of chapter 58 of the laws of 2007 amending the public health law, the public officers law and the state finance law relating to establishing the empire state stem cell board, in relation to the discontinuation of the empire clinical research investigator program (Part M); to amend the public health law and the education law, in relation to eliminating certain electronic prescription exemptions; and to repeal certain provisions of the public health law and the education law relating thereto (Part N); to repeal certain provisions of the social services law relating to the enhanced quality of adult living program ("EQUAL") grants; to repeal certain provisions of the public health law relating to requiring that the department of health audit hospital working hours; and to repeal certain provisions of the social services law relating to the provision providing operating subsidies to certain publicly operated adult care facilities (Part O); to amend the public health law, the education law, the insurance law and the social services law, in relation to expanding the role of pharmacists; to amend chapter 563 of the laws of 2008, amending the education law and the public health law relating to immunizing agents to be administered to adults by pharmacists, in relation to making such provisions permanent; to amend chapter 116 of the laws of 2012, amending the education law relating to authorizing a licensed pharmacist and certified nurse practitioner to administer certain immunizing agents, in relation to the effectiveness thereof; to amend chapter 274 of the laws of 2013, amending the education law

relating to authorizing a licensed pharmacist and certified nurse practitioner to administer meningococcal disease immunizing agents, in relation to the effectiveness thereof; and to amend chapter 21 of the laws of 2011, amending the education law relating to authorizing pharmacists to perform collaborative drug therapy management with physicians in certain settings, in relation to making such provisions permanent (Part P); to amend the education law and the public health law, in relation to the state's physician profiles and enhancing the ability of the department of education to investigate, discipline, and monitor licensed physicians, physician assistants, and specialist assistants (Part Q); to amend the civil rights law, in relation to a change of sex designation (Part R); to amend chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, in relation to extending the provisions thereof; to amend chapter 109 of the laws of 2010, amending the social services law relating to transportation costs, in relation to the effectiveness thereof; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to the effectiveness thereof; to amend chapter 56 of the laws of 2013 amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates, in relation to extending government rates for behavioral services and adding an alternative payment methodology requirement; to amend chapter 57 of the laws of 2019 amending the public health law relating to waiver of certain regulations, in relation to the effectiveness thereof; to amend chapter 517 of the laws of 2016, amending the public health law relating to payments from the New

York state medical indemnity fund, in relation to the effectiveness thereof; to amend the public health law, in relation to improved integration of health care and financing; and to amend chapter 56 of the laws of 2014, amending the education law relating to the nurse practitioners modernization act, in relation to extending the provisions thereof (Part S); 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 T); to amend part L of chapter 59 of the laws of 2016, amending the mental hygiene law relating to the appointment of temporary operators for the continued operation of programs and the provision of services for persons with serious mental illness and/or developmental disabilities and/or chemical dependence, in relation to the effectiveness thereof (Part U); to amend part NN of chapter 58 of the laws of 2015, amending the mental hygiene law relating to clarifying the authority of the commissioners in the department of mental hygiene to design and implement time-limited demonstration programs in relation to the effectiveness thereof (Part V); 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 extending such provisions relating thereto (Part W); authorizing the office of mental health to redesign services of certain facilities and programs and to implement service reductions; and providing for the repeal of such

provisions upon expiration thereof (Part X); to amend the mental hygiene law, in relation to setting standards for addiction professionals (Part Y); to amend the mental hygiene law, in relation to imposing sanctions due to a provider's failure to comply with the terms of their operating certificate or applicable law and to charge an application processing fee for the issuance of operating certificates (Part Z); to amend the mental hygiene law and the social services law, in relation to crisis stabilization services (Subpart A); to amend the mental hygiene law in relation to Kendra's law and assisted outpatient treatment (Subpart B); and to amend the mental hygiene law, in relation to involuntary commitment (Subpart C) (Part AA); to amend the mental hygiene law, in relation to establishing the New York state institute for basic research in developmental disabilities (Part BB); to amend the mental hygiene law, in relation to creating the office of addiction and mental health services (Part CC); to amend the social services law, the public health law and the mental hygiene law, in relation to setting comprehensive outpatient services (Part DD); and to repeal subdivision 10 of section 553 of the executive law, relating to the requirement that the justice center administer an adult home and residence for adults resident advocacy program (Part EE)

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 2021-2022 state fiscal year. Each component is wholly contained within a Part identified as Parts A through EE. 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 known and projected department of health state fund Medicaid expenditures, as amended by section 1 of part CCC of chapter 56 of the laws of 2020, is amended to read as follows:

(a) For state fiscal years 2011-12 through [2021-22] <u>2022-23</u>, the director of the budget, in consultation with the commissioner of health referenced as "commissioner" for purposes of this section, shall assess on a monthly basis, as reflected in monthly 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.

PART B

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. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2021.

PART C

Section 1. The public health law is amended by adding a new section 2807-pp to read as follows:

§ 2807-pp. 340B reimbursement fund. 1. Notwithstanding any inconsistent provision of law and subject to the availability of federal financial participation, there is hereby created a fund to support activities that expand health services to the medicaid members, the uninsured, and low-income patients, as supported by the 340B program. All funds available for distribution pursuant to this section shall be reserved and set aside and distributed in accordance with this section.

2. Each eligible 340B provider shall receive a proportionate distribution to be determined by a methodology established by the commissioner. Annual aggregate distributions pursuant to this section for the fiscal year from April first, two thousand twenty-one to March thirty-first, two thousand twenty-two, and each fiscal year thereafter, shall be equal to one hundred two million dollars, but may be increased by additional amounts authorized by the director of the division of the budget in consultation with the commissioner.

3. "Eligible 340B provider" means a voluntary non-profit or publicly sponsored diagnostic and treatment center licensed pursuant to this article twenty-eight that delivers a comprehensive range of health care services and that was enrolled in the 340B program pursuant to section

340B(a)(4) of the Federal Public Health Service act during the calendar year two thousand twenty and that submits to the department the annual recertification of participation in the 340B program as provided by the health resources and services administration.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2021.

PART D

Section 1. Paragraph (c) of subdivision 8 of section 2807-c of the public health law, as amended by section 2 of part KK of chapter 56 of the laws of 2020, 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 [on and after] 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, 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 any rate year, all reconciliation add-on amounts calculated on and after April first, two thousand twenty shall be reduced by ten percent, and all reconciliation recoupment amounts calculated on or after April first, two thousand twenty shall increase by ten percent. Notwithstanding any inconsistent provision of subparagraph (i) of paragraph (e) of subdivision nine of this section, capital related inpatient expenses of a general hospital included in the computation of rates of payment based on a budget shall not be included in the computation of a volume adjustment made in accordance with such subparagraph. Adjustments to rates of payment for a general hospital made pursuant to this paragraph shall be made in accordance with paragraph (c) of subdivision eleven of this section. Such adjustments shall not be carried forward except for such volume adjustment as may be authorized in accordance

with subparagraph (i) of paragraph (e) of subdivision nine of this section for such general hospital.

§ 2. Clause (A) of subparagraph (ii) of paragraph (b) of subdivision 5-d of section 2807-k of the public health law, as amended by section 3 of part KK of chapter 56 of the laws of 2020, is amended to read as follows:

(A) (1) subject to item two of this clause, one hundred thirty-nine million four hundred thousand dollars shall be distributed as Medicaid Disproportionate Share Hospital ("DSH") payments to major public general hospitals;

(2) for the calendar years two thousand twenty-one through two thousand twenty-two, and for each calendar year thereafter, the total distributions to major public general hospitals shall be reduced to zero dollars annually; and

§ 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2021; provided, however, that amendments to subdivision 5-d of section 2807-k of the public health law made by section two of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith.

PART E

Section 1. Clauses (M) and (N) of subparagraph (ii) of paragraph (bb) of subdivision 1 of section 2807-v of the public health law, as amended by section 14 of part Y of chapter 56 of the laws of 2020, are amended and a new clause (O) is added to read as follows:

(M) for each state fiscal year within the period April first, two thousand seventeen through March thirty-first, two thousand twenty, three hundred forty million dollars; [and]

(N) for each state fiscal year within the period April first, two thousand twenty through March thirty-first, two thousand [twenty-three] twenty-one, three hundred forty million dollars[.]; and

(O) for each state fiscal year within the period April first, two thousand twenty-one through March thirty-first, two thousand twenty-three, one hundred seventy million dollars and each state fiscal year thereafter.

§ 2. Subparagraphs (xiii) and (xiv) of paragraph (cc) of subdivision 1 of section 2807-v of the public health law, as amended by section 14 of part Y of chapter 56 of the laws of 2020, are amended and a new subparagraph (xv) is added to read as follows:

(xiii) up to eleven million two hundred thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty; [and]

(xiv) up to eleven million two hundred thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand [twenty-three.]twenty-one; and

(xv) up to five million six hundred thousand dollars for the state fiscal year commencing April first, two thousand twenty-one and each state fiscal year thereafter.

§ 3. Subparagraphs (ix) and (x) of paragraph (ccc) of subdivision 1 of section 2807-v of the public health law, as amended by section 14 of part Y of chapter 56 of the laws of 2020, are amended and a new subparagraph (xi) is added to read as follows:

(ix) up to fifty million dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty; [and]

(x) up to fifty million dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand [twenty-three.] twenty-one; and

(xi) up to twenty-five million dollars for each state fiscal year within the period April first, two thousand twenty-one through March thirty-first, two thousand twenty-three and each state fiscal year thereafter.

§ 4. The opening paragraph of paragraph (a) of subdivision 8 of section 3614 of the public health law, as amended by section 55 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

Notwithstanding any inconsistent provision of law, rule or regulation and subject to the provisions of paragraph (b) of this subdivision and to the availability of federal financial participation, the commissioner shall adjust medical assistance rates of payment for services provided by certified home health agencies for such services provided to children under eighteen years of age and for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the department, long term home health care programs and AIDS home care programs in accordance with this paragraph and paragraph (b) of this subdivision for purposes of improving recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility in the following amounts for services provided on and after December first, two thousand two, provided, however, for services provided in the state fiscal year commencing April

first, two thousand twenty-one such amounts shall be reduced by fifty percent.

§ 5. Subdivision 1 of section 4013 of the public health law, as amended by section 9 of part MM of chapter 56 of the laws of 2020, is amended to read as follows:

1. The commissioner shall, subject to the provisions of subdivision two of this section, increase medical assistance rates of payment by up to three percent for hospice services provided on and after December first, two thousand two, for purposes of improving recruitment and retention of non-supervisory workers or workers with direct patient care responsibility, provided, however, for services provided in the state fiscal year commencing April first, two thousand twenty-one such increase shall be up to one and one-half percent.

§ 6. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2021.

PART F

Section 1. Subdivision 3 of section 2999-cc of the public health law, as amended by section 2 of subpart C of part S of chapter 57 of the laws of 2018, is amended to read as follows:

3. "Originating site" means a site at which a patient is located at the time health care services are delivered to him or her by means of telehealth. [Originating sites shall be limited to: (a) facilities licensed under articles twenty-eight and forty of this chapter; (b) facilities as defined in subdivision six of section 1.03 of the mental hygiene law; (c) certified and non-certified day and residential programs funded or operated by the office for people with developmental

disabilities; (d) private physician's or dentist's offices located within the state of New York; (e) any type of adult care facility licensed under title two of article seven of the social services law; (f) public, private and charter elementary and secondary schools, school age child care programs, and child day care centers within the state of New York; and (g) the patient's place of residence located within the state of New York or other temporary location located within or outside the state of New York.]

§ 2. Paragraph (d) of subdivision 18-a of section 206 of the public health law, as amended by section 8 of part A of chapter 57 of the laws of 2015, is amended to read as follows:

(d) The commissioner may make such rules and regulations as may be necessary to implement federal policies and disburse funds as required by the American Recovery and Reinvestment Act of 2009 and to promote the development of a self-sufficient SHIN-NY to enable widespread, non-duplicative interoperability among disparate health information systems, including electronic health records, personal health records, health care claims, payment and other administrative data, and public health information systems, while protecting privacy and security. Such rules and regulations shall include, but not be limited to, requirements for organizations covered by 42 U.S.C. 17938 or any other organizations that exchange health information through the SHIN-NY or any other statewide health information system recommended by the workgroup. Such rules and regulations shall require that qualified entities permit access to all of a patient's information by all SHIN-NY participants or any other general designation of who may access such information after consent is obtained using a single statewide SHIN-NY consent form approved by the department and published on the department's website. If the commission-

er seeks to promulgate rules and regulations prior to issuance of the report identified in subparagraph (iv) of paragraph (b) of this subdivision, the commissioner shall submit the proposed regulations to the workgroup for its input. If the commissioner seeks to promulgate rules and regulations after the issuance of the report identified in such subparagraph (iv) then the commissioner shall consider the report and recommendations of the workgroup. If the commissioner acts in a manner inconsistent with the input or recommendations of the workgroup, he or she shall provide the reasons therefor.

§ 3. Paragraphs (w) and (x) of subdivision 2 of section 2999-cc of the public health law, as amended by section 1 of part HH of chapter 56 of the laws of 2020, are amended to read as follows:

(w) a care manager employed by or under contract to a health home program, patient centered medical home, office for people with developmental disabilities Care Coordination Organization (CCO), hospice or a voluntary foster care agency certified by the office of children and family services certified and licensed pursuant to article twenty-nine-i of this chapter; [and]

(x) practitioners authorized to provide services in New York pursuant to the interstate licensure program set forth in regulations promulgated by the commissioner of education in accordance with subdivision three of section sixty-five hundred one of the education law; and

(y) any other provider as determined by the commissioner pursuant to regulation or, in consultation with the commissioner, by the commissioner of the office of mental health, the commissioner of the office of addiction services and supports, or the commissioner of the office for people with developmental disabilities pursuant to regulation.

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

3. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, the commissioner shall, in consultation with the commissioners of the department of health, office of mental health, office of addiction services and supports, and office for people with developmental disabilities, issue regulations for the creation of an interstate licensure program which authorizes practitioners licensed by contiguous states or states in the Northeast region to provide telehealth services, as defined by article twenty-nine-g of the public health law and any implementing regulations promulgated by the commissioners of the department of health, office of mental health, office of addiction services and supports, and office for people with developmental disabilities, to patients located in New York state, taking into consideration the need for specialty practice areas with historical access issues, as determined by the commissioners of the department of health, office of mental health, office of addiction supports and services, or office for people with developmental disabilities. Such regulations may be promulgated on an emergency basis; provided, however, they shall be promulgated on a final basis no later than March thirty-first, two thousand twenty-two.

§ 5. Section 3217-h of the insurance law is amended by adding a new subsection (c) to read as follows:

(c) An insurer that provides comprehensive coverage for hospital, medical, or surgical care with a network of health care providers shall ensure that such network is adequate to meet the telehealth needs of insured individuals for services covered under the policy when medically appropriate.

§ 6. Section 4306-g of the insurance law is amended by adding a new subsection (c) to read as follows:

(c) A corporation that provides comprehensive coverage for hospital, medical, or surgical care with a network of health care providers shall ensure that such network is adequate to meet the telehealth needs of insured individuals for services covered under the policy when medically appropriate.

§ 7. Subdivisions 1 and 6 of section 24 of the public health law, as added by section 17 of part H of chapter 60 of the laws of 2014, are amended to read as follows:

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

6. A hospital shall post on the hospital's website: (a) the health care plans in which the hospital is a participating provider; (b) a statement that (i) physician services provided in the hospital are not included in the hospital's charges; (ii) physicians who provide services in the hospital may or may not participate with the same health care

plans as the hospital, and; (iii) the prospective patient should check with the physician arranging for the hospital services to determine the health care plans in which the physician participates; (c) as applicable, the name, mailing address and telephone number of the physician groups that the hospital has contracted with to provide services including anesthesiology, pathology or radiology, and instructions how to contact these groups to determine the health care plan participation of the physicians in these groups; [and] (d) as applicable, the name, mailing address, and telephone number of physicians employed by the hospital and whose services may be provided at the hospital, and the health care plans in which they participate; and (e) disclosure as to whether the hospital offers telehealth services.

§ 8. Subdivision 8 of section 24 of the public health law is amended by adding a new paragraph (d) to read as follows:

(d) "Telehealth services" means those services provided in accordance with article twenty-nine-g of this chapter, subsection (b) of section thirty-two hundred seventeen-h of the insurance law, or subsection (b) of section forty-three hundred six-g of the insurance law, as applicable.

§ 9. This act shall take effect April 1, 2021; provided, however, if this act shall have become a law after such date it shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2021; provided further, however, that the amendments to paragraph (d) of subdivision 18-a of section 206 of the public health law made by section two of this act shall not affect the repeal of such paragraph and shall be deemed repealed therewith; and provided further, that sections five and six of this act shall take effect October 1, 2021

and shall apply to policies and contracts issued, renewed, modified, altered, or amended on and after such date.

PART G

Section 1. The public health law is amended by adding a new article 29-J to read as follows:

ARTICLE 29-J

MEDICAL RESPITE PROGRAM

Section 2999-hh. Medical respite program.

§ 2999-hh. Medical respite program. 1. Legislative findings and purpose. The legislature finds that an individual who lacks access to safe housing faces an increased risk of adverse health outcomes. By offering medical respite programs as a lower-intensity care setting for individuals who would otherwise require a hospital stay or lack a safe option for discharge and recovery, medical respite programs will reduce hospital inpatient admissions and lengths of stay, hospital readmissions, and emergency room use. The legislature finds that the establishment of medical respite programs will protect the public interest and the interests of patients.

2. Definitions. As used in this article, the following terms shall have the following meanings, unless the context clearly otherwise requires:

(a) "Medical respite program" means a not-for-profit corporation licensed or certified pursuant to subdivision three of this section to serve recipients whose prognosis or diagnosis necessitates the receipt of:

(i) Temporary room and board; and

(ii) The provision or arrangement of the provision of health care and support services; provided, however, that the operation of a medical respite program shall be separate and distinct from any housing programs offered to individuals who do not qualify as recipients.

(b) "Recipient" means an individual who:

(i) Has a qualifying health condition that requires treatment or care;

(ii) Does not require hospital inpatient, observation unit, or emergency room level of care, or a medically indicated emergency department or observation visit; and

(iii) Is experiencing homelessness or at imminent risk of homelessness. (A) Subject to clause (B) of this subparagraph and any rules or regulations promulgated pursuant to subdivision four of this section, a person shall be deemed "homeless" if they are unable to secure or maintain permanent or stable housing without assistance.

(B) An operator of a medical respite program may establish eligibility standards using a more limited definition of "homelessness" if such limitation is necessary to ensure the availability of a funding source that will support the medical respite program's provision of room and board, and such limitations are otherwise consistent with any rules or regulations promulgated pursuant to subdivision four of this section. This applies to conditions that may exist in connection with:

(1) Public funding provided by a federal, state, or local government entity; or

(2) Subject to the approval of the department, private funding from a charitable entity or other non-governmental source.

3. Licensure or certification. (a) Notwithstanding any inconsistent provision of law, the commissioner may license or certify a not-for-profit corporation as an operator of a medical respite program.

(b) The commissioner may promulgate rules and regulations to establish procedures to review and approve applications for a license or certification pursuant to this article, which may be promulgated on an emergency basis and which shall, at a minimum, specify standards for: recipient eligibility; mandatory medical respite program services; physical environment; staffing; and policies and procedures governing health and safety, length of stay, referrals, discharge, and coordination of care.

4. Operating standards; responsibility for standards. (a) Medical respite programs licensed or certified pursuant to this article shall:

(i) Provide recipients with temporary room and board; and

(ii) Provide, or arrange for the provision of, health care and support services to recipients.

(b) Nothing contained within this article shall affect the application, qualification, or requirements that may apply to an operator with respect to any other licenses or operating certificates that such operator may hold, including, without limitation, under article twenty-eight of this chapter or article seven of the social services law.

5. Temporary accommodation. A medical respite program shall be considered a form of emergency shelter or temporary shelter for purposes of determining a recipient's eligibility for housing programs or benefits administered by the state or by a local social services district, including programs or benefits that support access to accommodations of a temporary, transitional, or permanent nature.

6. Inspections and compliance. The commissioner shall have the power to inquire into the operation of any licensed or certified medical respite program and to conduct periodic inspections of facilities with respect to the fitness and adequacy of the premises, equipment, personnel, rules and by-laws, standards of medical care and services, system

of accounts, records, and the adequacy of financial resources and sources of future revenues.

7. Suspension or revocation of license or certification. (a) A license or certification for a medical respite program under this article may be revoked, suspended, limited, annulled or denied by the commissioner, in consultation with either the commissioners of the office of mental health, the office of temporary and disability assistance, or the office of addiction services and supports, as appropriate based on a determination of the department depending on the diagnosis or stated needs of the individuals being served or proposed to be served in the medical respite program being considered for revocation, suspension, limitation, annulment or denial of certification, if an operator is determined to have failed to comply with the provisions of this article or the rules and regulations promulgated thereunder. No action taken against an operator under this subdivision shall affect an operator's other licenses or certifications; provided however, that the facts that gave rise to the revocation, suspension, limitation, annulment or denial of certification may also form the basis of a limitation, suspension of revocation of such other licenses or certifications.

(b) No such medical respite program license or certification shall be revoked, suspended, limited, annulled or denied without a hearing; provided that a license or certification may be temporarily suspended or limited without a hearing for a period not in excess of thirty days upon written notice that the continuation of the medical respite program places the public health or safety of the recipients in imminent danger.

(c) Nothing in this section shall prevent the commissioner from imposing sanctions or penalties on a medical respite program that are authorized under any other law or regulation.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2021.

PART H

Section 1. The title heading of title 11-D of article 5 of the social services law, as added by chapter 1 of the laws of 1999, is amended to read as follows:

[FAMILY] BASIC HEALTH [PLUS] PROGRAM

§ 2. Paragraph (d) of subdivision 3, subdivision 5 and subdivision 7 of section 369-gg of the social services law, as added by section 51 of part C of chapter 60 of the laws of 2014 and subdivision 7 as renumbered by section 28 of part B of chapter 57 of the laws of 2015, are amended to read as follows:

(d) (i) has household income at or below two hundred percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; and (ii) has household income that exceeds one hundred thirty-three percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; however, MAGI eligible aliens lawfully present in the United States with household incomes at or below one hundred thirty-three percent of the federal poverty line shall be eligible to receive coverage for health care services pursuant to the provisions of this title if such alien would be ineligible for medical assistance under title eleven of this article due to his or her immigration status.

An applicant who fails to make an applicable premium payment, if any, shall lose eligibility to receive coverage for health care services in accordance with time frames and procedures determined by the commissioner.

5. Premiums and cost sharing. (a) Subject to federal approval, the commissioner shall establish premium payments enrollees shall pay to approved organizations for coverage of health care services pursuant to this title. [Such premium payments shall be established in the following manner:

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

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

(b) The commissioner shall establish cost sharing obligations for enrollees, subject to federal approval.

7. Any funds transferred by the secretary of health and human services to the state pursuant to 42 U.S.C. 18051(d) shall be deposited in trust. Funds from the trust shall be used for providing health benefits through an approved organization, which, at a minimum, shall include essential health benefits as defined in 42 U.S.C. 18022(b); to reduce the premiums, if any, and cost sharing of participants in the basic health program; or for such other purposes as may be allowed by the secretary

of health and human services. Health benefits available through the basic health program shall be provided by one or more approved organizations pursuant to an agreement with the department of health and shall meet the requirements of applicable federal and state laws and regulations.

§ 3. This act shall take effect June 1, 2021 and shall expire and be deemed repealed should federal approval be withdrawn or 42 U.S.C. 18022(b) 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. 18022(b) 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 I

Section 1. 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:

1. (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, 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;

(b) certify and make available to qualified individuals, qualified health plans, including dental plans, certified by the Marketplace pursuant to applicable law, provided that coverage under such plans shall not become effective prior to certification by the Marketplace; [and]

(c) certify and/or make available to eligible individuals, health plans certified by the Marketplace pursuant to applicable law, and/or participating in an insurance affordability program pursuant to applicable law, provided that coverage under such plans shall not become effective prior to certification by the Marketplace, and/or approval by the commissioner[.]; and

(d) the commissioner, in cooperation with the superintendent, is authorized and directed, subject to the approval of the director of the division of the budget, to apply for federal waivers when such action would be necessary to assist in promoting the objectives of this section.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2021.

PART J

Section 1. The insurance law is amended by adding a new article 29 to read as follows:

ARTICLE 29

PHARMACY BENEFIT MANAGERS

Section 2901. Definitions.

§ 2901. Definitions. For purposes of this article:

(a) "Health plan" means an insurance company that is an authorized insurer under this chapter, a company organized pursuant to article forty-three of this chapter, a municipal cooperative health benefit plan established pursuant to article forty-seven of this chapter, an entity certified pursuant to article forty-four of the public health law including those providing services pursuant to title eleven of article five of the social services law and title one-A of article twenty-five of the public health law, an institution of higher education certified pursuant to section one thousand one hundred twenty-four of this chapter, the state insurance fund, and the New York state health insurance plan established under article eleven of the civil service law.

(b) "Pharmacy benefit management services" means the management or administration of prescription drug benefits pursuant to a contract with

a health plan, directly or through another entity, and regardless of whether the pharmacy benefit manager and the health plan are related, or associated by ownership, common ownership, organization or otherwise; including the procurement of prescription drugs to be dispensed to patients, or the administration or management of prescription drug benefits, including but not limited to, any of the following:

(1) mail service pharmacy;

(2) claims processing, retail network management, or payment of claims to pharmacies for dispensing prescription drugs;

(3) clinical or other formulary or preferred drug list development or management;

(4) negotiation or administration of rebates, discounts, payment differentials, or other incentives, for the inclusion of particular prescription drugs in a particular category or to promote the purchase of particular prescription drugs;

(5) patient compliance, therapeutic intervention, or generic substitution programs;

(6) disease management;

(7) drug utilization review or prior authorization;

(8) adjudication of appeals or grievances related to prescription drug coverage;

(9) contracting with network pharmacies; and

(10) controlling the cost of covered prescription drugs.

(c) "Pharmacy benefit manager" means any entity, including a wholly owned or partially owned or controlled subsidiary of a pharmacy benefits manager, that contracts to provide pharmacy benefit management services on behalf of a health plan.

(d) "Controlling person" means any person or other entity who or which directly or indirectly has the power to direct or cause to be directed the management, control or activities of a pharmacy benefit manager.

(e) "Covered individual" means a member, participant, enrollee, contract holder or policy holder or beneficiary of a health plan.

§ 2902. Acting without a registration. (a) No person, firm, association, corporation or other entity may act as a pharmacy benefit manager on or after June first, two thousand twenty-one and prior to January first, two thousand twenty-three, without having a valid registration as a pharmacy benefit manager filed with the superintendent in accordance with this article and any regulations promulgated thereunder.

(b) Any person, firm, association, corporation or other entity that violates this section shall, in addition to any other penalty provided by law, be liable for restitution to any health plan, pharmacy, or covered individual harmed by the violation and shall also be subject to a penalty not exceeding the greater of: (1) one thousand dollars for the first violation and two thousand five hundred dollars for each subsequent violation; or (2) the aggregate economic gross receipts attributable to all violations.

§ 2903. Registration requirements for pharmacy benefit managers. (a) Every pharmacy benefit manager that performs pharmacy benefit management services on or after June first, two thousand twenty-one and prior to January first, two thousand twenty-three shall register with the superintendent in a manner acceptable to the superintendent and shall pay a fee of one thousand dollars for each year or fraction of a year in which the registration shall be valid. The superintendent shall require that the pharmacy benefit manager disclose its officer or officers and director or directors who are responsible for the business entity's compli-

ance with the financial services and insurance laws, rules and regulations of this state. The registration shall detail the locations from which it provides services, and a listing of any entities with which it has contracts in New York state. The superintendent can reject a registration application filed by a pharmacy benefit manager that fails to comply with the minimum registration standards.

(b) For each business entity, the officer or officers and director or directors named in the application shall be designated responsible for the business entity's compliance with the financial services and insurance laws, rules and regulations of this state.

(c) Every registration will expire on December thirty-first, two thousand twenty-two regardless of when registration was first made.

(d) Every pharmacy benefit manager that performs pharmacy benefit management services at any time prior to June first, two thousand twenty-one, shall make the registration and fee payment required by subsection (a) of this section on or before June first, two thousand twenty-one. Any other pharmacy benefit manager shall make the registration and fee payment required by subsection (a) of this section prior to performing pharmacy benefit management services.

(e) Registrants under this section shall be subject to examination by the superintendent as often as the superintendent may deem it necessary. The superintendent may promulgate regulations establishing methods and procedures for facilitating and verifying compliance with the requirements of this article and such other regulations as necessary to enforce the provisions of this article.

§ 2904. Reporting requirements for pharmacy benefit managers. (a)(1) On or before July first of each year, beginning in two thousand twenty-two, every pharmacy benefit manager shall report to the superintendent,

in a statement subscribed and affirmed as true under penalties of perjury, the information requested by the superintendent including, without limitation:

(i) any pricing discounts, rebates of any kind, inflationary payments, credits, clawbacks, fees, grants, chargebacks, reimbursements, other financial or other reimbursements, incentives, inducements, refunds or other benefits received by the pharmacy benefit manager; and

(ii) the terms and conditions of any contract or arrangement, including other financial or other reimbursements incentives, inducements or refunds between the pharmacy benefit manager and any other party relating to pharmacy benefit management services provided to a health plan including but not limited to, dispensing fees paid to pharmacies.

(2) The superintendent may require the filing of quarterly or other statements, which shall be in such form and shall contain such matters as the superintendent shall prescribe.

(3) The superintendent may address to any pharmacy benefit manager or its officers any inquiry in relation to its provision of pharmacy benefit management services or any matter connected therewith. Every pharmacy benefit manager or person so addressed shall reply in writing to such inquiry promptly and truthfully, and such reply shall be, if required by the superintendent, subscribed by such individual, or by such officer or officers of the pharmacy benefit manager, as the superintendent shall designate, and affirmed by them as true under the penalties of perjury.

(b) In the event any pharmacy benefit manager or person does not submit a report required by paragraphs one or two of subsection (a) of this section or does not provide a good faith response to an inquiry from the superintendent pursuant to paragraph three of subsection (a) of this section within a time period specified by the superintendent of not

less than fifteen business days, the superintendent is authorized to levy a civil penalty, after notice and hearing, against such pharmacy benefit manager or person not to exceed one thousand dollars per day for each day beyond the date the report is due or the date specified by the superintendent for response to the inquiry.

(c) All documents, materials, or other information disclosed by a pharmacy benefit manager under this section which is in the control or possession of the superintendent shall be deemed confidential, shall not be disclosed, either pursuant to freedom of information requests or subpoena, and further shall not be subject to discovery or admissible in evidence in any private civil action; provided however that nothing in this subdivision shall prevent the superintendent, in his or her sole discretion, from providing to any other governmental entity information the superintendent deems necessary for the enforcement of the laws of this state or of the United States.

§ 2905. Acting without a license. (a) No person, firm, association, corporation or other entity may act as a pharmacy benefit manager on or after January first, two thousand twenty-three without having authority to do so by virtue of a license issued in force pursuant to the provisions of this article.

(b) Any person, firm, association, corporation or other entity that violates this section shall, in addition to any other penalty provided by law, be subject to a penalty not exceeding the greater of (1) one thousand dollars for the first violation and two thousand five hundred dollars for each subsequent violation or (2) the aggregate economic gross receipts attributable to all violations.

§ 2906. Licensing of a pharmacy benefit manager. (a) The superintendent may issue a pharmacy benefit manager's license to any person, firm,

association or corporation who or that has complied with the requirements of this article, including regulations promulgated by the superintendent. The superintendent, in consultation with the commissioner of health, may establish, by regulation, minimum standards for the issuance of a license to a pharmacy benefit manager.

(b) The minimum standards established under this section may address, without limitation:

(1) prohibitions on conflicts of interest between pharmacy benefit managers and health plans;

(2) prohibitions on deceptive practices in connection with the performance of pharmacy benefit management services;

(3) prohibitions on anti-competitive practices in connection with the performance of pharmacy benefit management services;

(4) prohibitions on pricing models, which may include prohibitions on spread pricing;

(5) prohibitions on unfair claims practices in connection with the performance of pharmacy benefit management services;

(6) codification of standards and practices in the creation of pharmacy networks and contracting with network pharmacies and other providers;

(7) prohibitions on contract provisions which arbitrarily require a pharmacy to meet any pharmacy accreditation standard or recertification requirement inconsistent with or more stringent than, or in addition to federal or state requirements and codification of standards and practices in the creation and use of specialty pharmacy networks; and

(8) best practices for protection of consumers.

(c) The superintendent may require any or all of the members, officers, directors, or designated employees of the applicant to be named in the application for a license under this article. For each business

entity, the officer or officers and director or directors named in the application shall be designated responsible for the business entity's compliance with the insurance laws, rules and regulations of this state.

(d)(1) Before a pharmacy benefit manager's license shall be issued or renewed, the prospective licensee shall properly file in the office of the superintendent a written application therefor in such form or forms and supplements thereto as the superintendent prescribes, and pay a fee of two thousand dollars for each year or fraction of a year in which a license shall be valid.

(2) Every pharmacy benefit manager's license shall expire thirty-six months after the date of issue. Every license issued pursuant to this section may be renewed for the ensuing period of thirty-six months upon the filing of an application in conformity with this subsection.

(e) If an application for a renewal license shall have been filed with the superintendent at least two months before its expiration, then the license sought to be renewed shall continue in full force and effect either until the issuance by the superintendent of the renewal license applied for or until five days after the superintendent shall have refused to issue such renewal license and given notice of such refusal to the applicant.

(f) The superintendent may refuse to issue a pharmacy benefit manager's license if, in the superintendent's judgment, the applicant or any member, principal, officer or director of the applicant, is not trustworthy and competent to act as or in connection with a pharmacy benefit manager, or that any of the foregoing has given cause for revocation or suspension of such license, or has failed to comply with any prerequisite for the issuance of such license. As a part of such determination, the superintendent is authorized to fingerprint applicants or any

member, principal, officer or director of the applicant for licensure. Such fingerprints shall be submitted to the division of criminal justice services for a state criminal history record check, as defined in subdivision one of section three thousand thirty-five of the education law, and may be submitted to the federal bureau of investigation for a national criminal history record check.

(g) Licensees and applicants for a license under this section shall be subject to examination by the superintendent as often as the superintendent may deem it expedient. The superintendent may promulgate regulations establishing methods and procedures for facilitating and verifying compliance with the requirements of this section and such other regulations as necessary.

(h) The superintendent may issue a replacement for a currently in-force license that has been lost or destroyed. Before the replacement license shall be issued, there shall be on file in the office of the superintendent a written application for the replacement license, affirming under penalty of perjury that the original license has been lost or destroyed, together with a fee of two hundred dollars.

(i) No pharmacy benefit manager shall engage in any practice or action that a health plan is prohibited from engaging in pursuant to this chapter.

§ 2907. Revocation or suspension of a registration or license of a pharmacy benefit manager. (a) The superintendent may refuse to renew, may revoke, or may suspend for a period the superintendent determines the registration or license of any pharmacy benefit manager if, the superintendent determines that the registrant or licensee or any member, principal, officer, director, or controlling person of the registrant or licensee, has:

(1) violated any insurance laws, section two hundred eighty-a or two hundred eighty-c of the public health law or violated any regulation, subpoena or order of the superintendent or of another state's insurance commissioner, or has violated any law in the course of its dealings in such capacity after such license has been issued or renewed pursuant to section two thousand nine hundred six of this article;

(2) provided materially incorrect, materially misleading, materially incomplete or materially untrue information in the registration or license application;

(3) obtained or attempted to obtain a registration or license through misrepresentation or fraud;

(4)(i) used fraudulent, coercive or dishonest practices;

(ii) demonstrated incompetence;

(iii) demonstrated untrustworthiness; or

(iv) demonstrated financial irresponsibility in the conduct of business in this state or elsewhere;

(5) improperly withheld, misappropriated or converted any monies or properties received in the course of business in this state or elsewhere;

(6) intentionally misrepresented the terms of an actual or proposed insurance contract;

(7) admitted or been found to have committed any insurance unfair trade practice or fraud;

(8) had a pharmacy benefit manager registration or license, or its equivalent, denied, suspended or revoked in any other state, province, district or territory;

(9) failed to pay state income tax or comply with any administrative or court order directing payment of state income tax;

(10) failed to pay any assessment required by this article; or

(11) ceased to meet the requirements for registration or licensure under this article.

(b) Before revoking or suspending the registration or license of any pharmacy benefit manager pursuant to the provisions of this article, the superintendent shall give notice to the registrant or licensee and shall hold, or cause to be held, a hearing not less than ten days after the giving of such notice.

(c) If a registration or license pursuant to the provisions of this article is revoked or suspended by the superintendent, then the superintendent shall forthwith give notice to the registrant or licensee.

(d) The revocation or suspension of any registration or license pursuant to the provisions of this article shall terminate forthwith such registration or license and the authority conferred thereby upon all licensees. For good cause shown, the superintendent may delay the effective date of a revocation or suspension to permit the registrant or licensee to satisfy some or all of its contractual obligations to perform pharmacy benefit management services in the state.

(e)(1) No individual, corporation, firm or association whose registration or license as a pharmacy benefit manager has been revoked pursuant to subsection (a) of this section, and no firm or association of which such individual is a member, and no corporation of which such individual is an officer or director, and no controlling person of the registrant or licensee shall be entitled to obtain any registration or license under the provisions of this article for a minimum period of one year after such revocation, or, if such revocation be judicially reviewed, for a minimum period of one year after the final determination thereof affirming the action of the superintendent in revoking such license.

(2) If any such registration or license held by a firm, association or corporation be revoked, no member of such firm or association and no officer or director of such corporation or any controlling person of the registrant or licensee shall be entitled to obtain any registration or license, under this article for the same period of time, unless the superintendent determines, after notice and hearing, that such member, officer or director was not personally at fault in the matter on account of which such registration or license was revoked.

(f) If any corporation, firm, association or person aggrieved shall file with the superintendent a verified complaint setting forth facts tending to show sufficient ground for the revocation or suspension of any pharmacy benefit manager's registration or license, then if the superintendent finds the complaint credible, the superintendent shall, after notice and a hearing, determine whether such registration or license shall be suspended or revoked.

(g) The superintendent shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this chapter against any person or entity who is under investigation for or charged with a violation of this chapter, even if the person's or entity's registration or license has been surrendered, or has expired or has lapsed by operation of law.

(h) A registrant or licensee subject to this article shall report to the superintendent any administrative action taken against the registrant or licensee or any of the members, officers, directors, or designated employees of the applicant named in the registration or licensing application in another jurisdiction or by another governmental agency in this state within thirty days of the final disposition of the matter.

This report shall include a copy of the order, consent to order or other relevant legal documents.

(i) Within thirty days of the initial pretrial hearing date, a registrant or licensee subject to this article shall report to the superintendent any criminal prosecution of the registrant or licensee or any of the members, officers, directors, or designated employees of the applicant named in the registration or licensing application taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing and any other relevant legal documents.

§ 2908. Penalties for violations. (a) In addition to any other power conferred by law, the superintendent may in any one proceeding by order, require a registrant or licensee who has violated any provision of this article or whose license would otherwise be subject to revocation or suspension to pay to the people of this state a penalty in a sum not exceeding the greater of: (1) one thousand dollars for each offense and two thousand five hundred dollars for each subsequent violation; or (2) the aggregate gross receipts attributable to all offenses.

(b) Upon the failure of such a registrant or licensee to pay the penalty ordered pursuant to subsection (a) of this section within twenty days after the mailing of the order, postage prepaid, registered, and addressed to the last known place of business of the licensee, unless the order is stayed by an order of a court of competent jurisdiction, the superintendent may revoke the registration or license of the registrant or licensee or may suspend the same for such period as the superintendent determines.

§ 2909. Stay or suspension of superintendent's determination. The commencement of a proceeding under article seventy-eight of the civil

practice law and rules, to review the action of the superintendent in suspending or revoking or refusing to renew any certificate under this article, shall stay such action of the superintendent for a period of thirty days. Such stay shall not be extended for a longer period unless the court shall determine, after a preliminary hearing of which the superintendent is notified forty-eight hours in advance, that a stay of the superintendent's action pending the final determination or further order of the court will not injure the interests of the people of the state.

§ 2910. Revoked registrations or licenses. (a)(1) No person, firm, association, corporation or other entity subject to the provisions of this article whose registration or license under this article has been revoked, or whose registration or license to engage in the business of pharmacy benefit management in any capacity has been revoked by any other state or territory of the United States shall become employed or appointed by a pharmacy benefit manager as an officer, director, manager, controlling person or for other services, without the prior written approval of the superintendent, unless such services are for maintenance or are clerical or ministerial in nature.

(2) No person, firm, association, corporation or other entity subject to the provisions of this article shall knowingly employ or appoint any person or entity whose registration or license issued under this article has been revoked, or whose registration or license to engage in the business of pharmacy benefit management in any capacity has been revoked by any other state or territory of the United States, as an officer, director, manager, controlling person or for other services, without the prior written approval of the superintendent, unless such services are for maintenance or are clerical or ministerial in nature.

(3) No corporation or partnership subject to the provisions of this article shall knowingly permit any person whose registration or license issued under this article has been revoked, or whose registration or license to engage in the business of pharmacy benefit management in any capacity has been revoked by any other state, or territory of the United States, to be a shareholder or have an interest in such corporation or partnership, nor shall any such person become a shareholder or partner in such corporation or partnership, without the prior written approval of the superintendent.

(b) The superintendent may approve the employment, appointment or participation of any such person whose registration or license has been revoked:

(1) if the superintendent determines that the duties and responsibilities of such person are subject to appropriate supervision and that such duties and responsibilities will not have an adverse effect upon the public, other registrants or licensees, or the registrant or licensee proposing employment or appointment of such person; or

(2) if such person has filed an application for reregistration or relicensing pursuant to this article and the application for reregistration or relicensing has not been approved or denied within one hundred twenty days following the filing thereof, unless the superintendent determines within the said time that employment or appointment of such person by a registrant or licensee in the conduct of a pharmacy benefit management business would not be in the public interest.

(c) The provisions of this section shall not apply to the ownership of shares of any corporation registered or licensed pursuant to this article if the shares of such corporation are publicly held and traded in

the over-the-counter market or upon any national or regional securities exchange.

§ 2911. Change of address. A registrant or licensee under this article shall inform the superintendent by a means acceptable to the superintendent of a change of address within thirty days of the change.

§ 2912. Duties. (a) A pharmacy benefit manager shall be required to adhere to the code of conduct, as the superintendent may establish by regulation pursuant to section twenty-nine hundred six of this article.

(b) No contract with a health plan shall limit access to financial or utilization information of the pharmacy benefit manager in relation to pharmacy benefit management services provided to the health plan.

(c) A pharmacy benefit manager shall disclose in writing to a health plan with whom a contract for pharmacy benefit management services has been executed any activity, policy, practice, contract or arrangement of the pharmacy benefit manager that directly or indirectly presents a conflict of interest with the pharmacy benefit manager's contractual relationship with, or duties and obligations to, the health plan.

(d) A pharmacy benefit manager shall assist a health plan in answering any inquiry made under section three hundred eight of this chapter.

(e) No pharmacy benefit manager shall violate any provision of the public health law applicable to pharmacy benefit managers.

(f) (1) Any information required to be disclosed by a pharmacy benefit manager to a health plan under this section that is reasonably designated by the pharmacy benefit manager as proprietary or trade secret information shall be kept confidential by the health plan, except as required or permitted by law or court order, including disclosure necessary to prosecute or defend any legitimate legal claim or cause of action.

(2) Designation as proprietary or trade secret information under this subsection shall have no effect on the obligations of any pharmacy benefit manager or health plan to provide that information to the department.

§ 2913. Applicability of other laws. Nothing in this article shall be construed to exempt a pharmacy benefit manager from complying with the provisions of articles twenty-one and forty-nine of this chapter and articles forty-four and forty-nine and sections two hundred eighty-a and two hundred eighty-c of the public health law, section three hundred sixty-four-j of the social services law, or any other provision of this chapter or the financial services law.

§ 2914. Assessments. Notwithstanding section two hundred six of the financial services law, pharmacy benefit managers that file a registration with the department or are licensed by the department shall be assessed by the superintendent for the operating expenses of the department that are attributable to regulating such pharmacy benefit managers in such proportions as the superintendent shall deem just and reasonable.

§ 2. Subsection (b) of section 2402 of the insurance law, as amended by section 71 of part A of chapter 62 of the laws of 2011, is amended to read as follows:

(b) "Defined violation" means the commission by a person of an act prohibited by: subsection (a) of section one thousand one hundred two, section one thousand two hundred fourteen, one thousand two hundred seventeen, one thousand two hundred twenty, one thousand three hundred thirteen, subparagraph (B) of paragraph two of subsection (i) of section one thousand three hundred twenty-two, subparagraph (B) of paragraph two of subsection (i) of section one thousand three hundred twenty-four, two

thousand one hundred two, two thousand one hundred seventeen, two thousand one hundred twenty-two, two thousand one hundred twenty-three, subsection (p) of section two thousand three hundred thirteen, section two thousand three hundred twenty-four, two thousand five hundred two, two thousand five hundred three, two thousand five hundred four, two thousand six hundred one, two thousand six hundred two, two thousand six hundred three, two thousand six hundred four, two thousand six hundred six, two thousand seven hundred three, <u>two thousand nine hundred two, two thousand nine hundred five,</u> three thousand one hundred nine, three thousand two hundred twenty-four-a, three thousand four hundred twenty-nine, three thousand four hundred thirty-three, paragraph seven of subsection (e) of section three thousand four hundred twenty-six, four thousand two hundred twenty-four, four thousand two hundred twenty-five, four thousand two hundred twenty-six, seven thousand eight hundred nine, seven thousand eight hundred ten, seven thousand eight hundred eleven, seven thousand eight hundred thirteen, seven thousand eight hundred fourteen and seven thousand eight hundred fifteen of this chapter; or section 135.60, 135.65, 175.05, 175.45, or 190.20, or article one hundred five of the penal law.

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

§ 4. This act shall take effect immediately.

PART K

Section 1. 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 is amended by adding a new subdivision 9 to read as follows:

(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, 2021, 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 (e) 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 (c) 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.

(b) If at the conclusion of the policy period, a physician or dentist, eligible for excess coverage paid for from funds available in the hospi-

tal excess liability pool, has failed to pay an amount equal to fifty percent of the premium as established pursuant to paragraph (c) 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.

(c) 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, 2021, 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, 2020.

(d) 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.

(e) 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.

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

§ 2. 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 AAA of chapter 56 of the laws of 2020, is amended to read as follows:

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

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("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.

§ 3. 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 AAA of chapter 56 of the laws of 2020, 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, [and] between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, [and] 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, [and] between July 1, 2020 and June 30, 2021<u>, and between July 1, 2021 and June 30, 2022</u> 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, [and] between July 1, 2020 and June 30, 2021, and between July 1, 2021 and June 30, 2022 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 neces-

sary. 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, [and] to the period July 1, 2020 to June 30, 2021, and to the period July 1, 2021 to June 30, 2022.

§ 4. 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 AAA of chapter 56 of the laws of 2020, 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, [and] during the period July 1, 2020 to June 30, 2021, and during the period July 1, 2021 to June 30, 2022 allocated or reallocated in accordance with paragraph (a) of subdivision 4-a of this section to rates of payment applicable to state governmental agencies, each physician or dentist for whom a policy for excess insurance coverage or equivalent excess coverage is purchased for such period shall be responsible for payment to the provider of excess insurance coverage or equivalent excess coverage of an allocable share of such insufficiency, based on the ratio of the total cost of such coverage for such physician to the sum of the total cost of such coverage for all physicians applied to such insufficiency.

(b) Each provider of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30,

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

§ 5. 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 5 of part AAA of chapter 56 of the laws of 2020, 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, [2021] 2022; 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, [2021] 2022, 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, [2021] 2022 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 defi-ciency 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.

§ 6. 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 6 of part AAA of chapter 56 of the laws of 2020, 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, [and] June 15, 2021<u>, and June 15, 2022</u> 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 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 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, [and] June 15, 2021, and June 15, 2022 as applicable.

§ 7. 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 7 of part AAA of chapter 56 of the laws of 2020, 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 liabil-

ity 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] twenty-one, shall be eligible to apply for such coverage for the coverage period beginning the first of July, two thousand [twenty] twenty-one; 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] twenty-one exceeds the total number of physicians or dentists certified as eligible for the coverage period beginning the first of July, two thousand [twenty] twenty-one, 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] twenty-one, 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] twenty-one 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] twenty-one.

§ 8. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2021.

PART L

Section 1. Subdivision 2 of section 605 of the public health law, as amended by section 1 of part O of chapter 57 of the laws of 2019, is amended to read as follows:

2. State aid reimbursement for public health services provided by a municipality under this title, shall be made if the municipality is providing some or all of the core public health services identified in section six hundred two of this title, pursuant to an approved application for state aid, at a rate of no less than thirty-six per centum, except for the city of New York which shall receive no less than [twenty] ten per centum, of the difference between the amount of moneys expended by the municipality for public health services required by section six hundred two of this title during the fiscal year and the base grant provided pursuant to subdivision one of this section. No such reimbursement shall be provided for services that are not eligible for state aid pursuant to this article.

§ 2. Subdivision 1 of section 616 of the public health law, as amended by section 2 of part O of chapter 57 of the laws of 2019, is amended to read as follows:

1. The total amount of state aid provided pursuant to this article shall be limited to the amount of the annual appropriation made by the legislature. In no event, however, shall such state aid be less than an amount to provide the full base grant and, as otherwise provided by subdivision two of section six hundred five of this article, no less than thirty-six per centum, except for the city of New York which shall receive no less than [twenty] ten per centum, of the difference between the amount of moneys expended by the municipality for eligible public health services pursuant to an approved application for state aid during

the fiscal year and the base grant provided pursuant to subdivision one of section six hundred five of this article.

§ 3. This act shall take effect July 1, 2021.

PART M

Section 1. 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 5-a as amended and paragraph (d) of subdivision 5 as added by section 6 of part Y of chapter 56 of the laws of 2020, 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, and 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, 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 subpar-

agraph. Such distributions shall be made in accordance with the follow-
ing 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 gener-

al 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, and 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, 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, and 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, 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 [(c) and (d) (e)] (b) and (c) 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 thou-

sand seventeen through March thirty-first, two thousand twenty, and 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, 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, and 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,

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.

§ 2. 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.

§ 3. 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.

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

2. Solicit, receive, and review applications from public and private agencies and organizations and qualified research institutions for grants from the spinal cord injury research trust fund, created pursuant to section ninety-nine-f of the state finance law, to conduct research programs which focus on the treatment and cure of spinal cord injury. The board shall make recommendations to the commissioner, and the commissioner shall, in his or her discretion, grant approval of applications for grants from those applications recommended by the board; provided, however, that the board shall not recommend, and the commissioner shall not approve, any new grants on or after April first, two thousand twenty-one.

§ 5. Subdivision 1 of section 265-a of the public health law, as added by section 1 of part H of chapter 58 of the laws of 2007, is amended to read as follows:

1. The empire state stem cell board ("board"), comprised of a funding committee and an ethics committee, both of which shall be chaired by the commissioner, is hereby created within the department for the purpose of administering the empire state stem cell trust fund ("fund"), created pursuant to section ninety-nine-p of the state finance law. The board is hereby empowered, subject to annual appropriations and other funding authorized or made available, to make grants to basic, applied, translational or other research and development activities that will advance scientific discoveries in fields related to stem cell biology; provided,

however, that the board shall not make any grants on or after April first, two thousand twenty-one.

§ 6. Section 6 of chapter 338 of the laws of 1998 amending the public health law, the public officers law and the state finance law relating to establishing a spinal cord injury research board, is amended to read as follows:

§ 6. This act shall take effect January 1, 1999 and shall expire and be deemed repealed December 31, 2024.

§ 7. Section 4 of part H of chapter 58 of the laws of 2007 amending the public health law, the public officers law and the state finance law relating to establishing the empire state stem cell board, is amended to read as follows:

§ 4. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2007 and shall expire and be deemed repealed December 31, 2025.

§ 8. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2021; 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 two of this act shall not affect the expiration of such section and shall be deemed to expire therewith; provided further, however, that the amendments to section 251 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; and provided further, however, the amendments to section 265-a of the public health law made by section five of this act shall not affect the expiration of such section and shall be deemed to expire therewith.

PART N

Section 1. Subdivision 3 of section 281 of the public health law, as amended by chapter 13 of the laws of 2015, is amended to read as follows:

3. On or before December thirty-first, two thousand twelve, the commissioner shall promulgate regulations, in consultation with the commissioner of education, establishing standards for electronic prescriptions. Notwithstanding any other provision of this section or any other law to the contrary, effective three years subsequent to the date on which such regulations are promulgated, no person shall issue any prescription in this state unless such prescription is made by electronic prescription from the person issuing the prescription to a pharmacy in accordance with such regulatory standards, except for prescriptions: (a) [issued by veterinarians; (b)] issued in circumstances where electronic prescribing is not available due to temporary technological or electrical failure, as set forth in regulation; [(c)] (b) issued by practitioners [who have received a waiver or a renewal thereof for a specified period determined by the commissioner, not to exceed one year, from the requirement to use electronic prescribing, pursuant to a process established in regulation by the commissioner, in consultation with the commissioner of education, due to economic hardship, technological limitations that are not reasonably within the control of the practitioner, or other] in such exceptional [circumstance demonstrated by the practitioner; (d)] circumstances as may be determined by the commissioner; (c) issued by a practitioner under circumstances where, notwithstanding the practitioner's present ability to make an electronic prescription as required by this subdivision, such

practitioner reasonably determines that it would be impractical for the patient to obtain substances prescribed by electronic prescription in a timely manner, and such delay would adversely impact the patient's medical condition, provided that if such prescription is for a controlled substance, the quantity of controlled substances does not exceed a five day supply if the controlled substance were used in accordance with the directions for use; or [(e)] (d) issued by a practitioner to be dispensed by a pharmacy located outside the state, as set forth in regulation.

§ 2. Subdivision 5 of section 281 of the public health law, as amended by chapter 350 of the laws of 2016, is amended to read as follows:

5. In the case of a prescription for a controlled substance issued by a practitioner under paragraph [(d)] (c) or [(e)] (d) of subdivision three of this section, the practitioner shall, upon issuing such prescription, indicate in the patient's health record either that the prescription was issued other than electronically because it (a) was impractical to issue an electronic prescription in a timely manner and such delay would have adversely impacted the patient's medical condition, or (b) was to be dispensed by a pharmacy located outside the state.

§ 3. Subdivision 10 of section 6810 of the education law, as amended by chapter 13 of the laws of 2015, is amended to read as follows:

10. Notwithstanding any other provision of this section or any other law to the contrary, effective three years subsequent to the date on which regulations establishing standards for electronic prescriptions are promulgated by the commissioner of health, in consultation with the commissioner pursuant to subdivision three of section two hundred eighty-one of the public health law, no practitioner shall issue any

prescription in this state, unless such prescription is made by electronic prescription from the practitioner to a pharmacy, except for prescriptions: (a) [issued by veterinarians; (b)] issued or dispensed in circumstances where electronic prescribing is not available due to temporary technological or electrical failure, as set forth in regulation; [(c)] (b) issued by practitioners [who have received a waiver or a renewal thereof for a specified period determined by the commissioner of health, not to exceed one year, from the requirement to use electronic prescribing, pursuant to a process established in regulation by the commissioner of health, in consultation with the commissioner due to economic hardship, technological limitations that are not reasonably within the control of the practitioner, or other] in such exceptional [circumstance demonstrated by the practitioner] circumstances as may be determined by the commissioner of health ; [(d)] (c) issued by a practitioner under circumstances where, notwithstanding the practitioner's present ability to make an electronic prescription as required by this subdivision, such practitioner reasonably determines that it would be impractical for the patient to obtain substances prescribed by electronic prescription in a timely manner, and such delay would adversely impact the patient's medical condition, provided that if such prescription is for a controlled substance, the quantity that does not exceed a five day supply if the controlled substance was used in accordance with the directions for use; or [(e)] (d) issued by a practitioner to be dispensed by a pharmacy located outside the state, as set forth in regulation.

§ 4. Subdivisions 11 and 12 of section 6810 of the education law, as amended by chapter 350 of the laws of 2016, are amended to read as follows:

11. In the case of a prescription issued by a practitioner under paragraph [(b)] (a) of subdivision ten of this section, the practitioner shall be required to indicate in the patient's health record that the prescription was issued other than electronically due to temporary technological or electrical failure.

12. In the case of a prescription issued by a practitioner under paragraph [(d)] (c) or [(e)] (d) of subdivision ten of this section, the practitioner shall, upon issuing such prescription, indicate in the patient's health record either that the prescription was issued other than electronically because it (a) was impractical to issue an electronic prescription in a timely manner and such delay would have adversely impacted the patient's medical condition, or (b) was to be dispensed by a pharmacy located outside the state.

§ 5. Subdivisions 6 and 7 of section 281 of the public health law are REPEALED.

§ 6. Subdivisions 13 and 15 of section 6810 of the education law are REPEALED.

§ 7. This act shall take effect on November 1, 2021.

PART O

Section 1. Section 461-s of the social services law is REPEALED.

§ 2. Subdivision 9 of section 2803 of the public health law is REPEALED.

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

§ 4. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2021.

PART P

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

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

§ 2. Section 6801 of the education law is amended by adding two new subdivisions 6 and 7 to read as follows:

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

7. A licensed pharmacist may act as a referring healthcare provider for diabetes self-management education and asthma self-management training.

§ 3. Subdivision 7 of section 6527 of the education law, as amended by chapter 110 of the laws of 2020, is amended to read as follows:

7. A licensed physician may prescribe and order a patient specific order or non-patient specific regimen to a licensed pharmacist, pursuant to regulations promulgated by the commissioner, and consistent with the

public health law, for administering immunizations to prevent influenza, pneumococcal, acute herpes zoster, meningococcal, tetanus, diphtheria, COVID-19, or pertussis disease or, for patients eighteen years of age or older, any other immunizations recommended by the advisory committee on immunization practices of the centers for disease control and prevention, and medications required for emergency treatment of anaphylaxis. Nothing in this subdivision shall authorize unlicensed persons to administer immunizations, vaccines or other drugs.

§ 4. Subdivision 7 of section 6909 of the education law, as amended by chapter 110 of the laws of 2020, is amended to read as follows:

7. A certified nurse practitioner may prescribe and order a patient specific order or non-patient specific regimen to a licensed pharmacist, pursuant to regulations promulgated by the commissioner, and consistent with the public health law, for administering immunizations to prevent influenza, pneumococcal, acute herpes zoster, meningococcal, tetanus, diphtheria, COVID-19, or pertussis disease or, for patients eighteen years of age or older, any other immunizations recommended by the advisory committee on immunization practices of the centers for disease control and prevention, and medications required for emergency treatment of anaphylaxis. Nothing in this subdivision shall authorize unlicensed persons to administer immunizations, vaccines or other drugs.

§ 5. Section 6801-a of the education law, as amended by chapter 238 of the laws of 2015, is amended to read as follows:

§ 6801-a. Collaborative drug therapy management [demonstration] program. 1. As used in this section, the following terms shall have the following meanings:

a. "Board" shall mean the state board of pharmacy as established by section sixty-eight hundred four of this article.

b. "Clinical services" shall mean the collection and interpretation of patient data for the purpose of [initiating, modifying and] monitoring drug therapy and prescribing in order to adjust or manage drug therapy, with associated accountability and responsibility for outcomes in a direct patient care setting.

c. "Collaborative drug therapy management" shall mean the performance of clinical services by a pharmacist relating to the review, evaluation and management of drug therapy to a patient, who is being treated by a physician, or nurse practitioner for a specific disease or associated disease states, in accordance with a written agreement or protocol with a voluntarily participating physician, or nurse practitioner and in accordance with the policies, procedures, and protocols of the facility. Such agreement or protocol as entered into by the physician, or nurse practitioner and a pharmacist, may include[, and shall be limited to]:

(i) [adjusting or managing] prescribing in order to adjust or manage a drug regimen of a patient, pursuant to a patient specific order or non-patient specific protocol made by the patient's physician or nurse practitioner, which may include adjusting drug strength, frequency of administration or route of administration[. Adjusting the drug regimen shall not include substituting] or selecting a [different] drug which differs from that initially prescribed by the patient's physician [unless such substitution is expressly] or nurse practitioner as authorized in the written [order] agreement or protocol. The pharmacist shall be required to immediately document in the patient record changes made to the patient's drug therapy and shall use any reasonable means or method established by the facility or practice to notify the patient's other treating physicians [with whom he or she does not have a written agreement or protocol regarding such changes. The patient's physician may

prohibit, by written instruction, any adjustment or change in the patient's drug regimen by the pharmacist], nurse practitioners and other health care professionals as required by the facility or the collaborative practice agreement;

(ii) evaluating [and, only if specifically] as authorized by the protocol and only to the extent necessary to discharge the responsibilities set forth in this section, ordering disease state laboratory tests related to the drug therapy management for the specific disease or disease [state] states specified within the written agreement or protocol; and

(iii) [only if specifically] as authorized by the written agreement or protocol and only to the extent necessary to discharge the responsibilities set forth in this section, ordering or performing routine patient monitoring functions as may be necessary in the drug therapy management, including the collecting and reviewing of patient histories, and ordering or checking patient vital signs[, including pulse, temperature, blood pressure and respiration].

d. "Facility" shall mean[: (i)] a [teaching hospital or] general hospital, [including any] diagnostic center, treatment center, or hospital-based outpatient department as defined in section twenty-eight hundred one of the public health law[; or (ii)], a nursing home, or any facility as defined in section twenty-eight hundred one of the public health law or other entity that provides direct patient care under the auspices of a medical director; with an on-site pharmacy staffed by a licensed pharmacist; provided, however, for the purposes of this section the term "facility" shall not include dental clinics, dental dispensaries[, residential health care facilities] and rehabilitation centers. In addition, a "practice" shall mean a place or situation in which physi-

cians and nurse practitioners either alone or in group practices provide diagnostic and treatment care for patients.

[For the purposes of this section, a "teaching hospital" shall mean a hospital licensed pursuant to article twenty-eight of the public health law that is eligible to receive direct or indirect graduate medical education payments pursuant to article twenty-eight of the public health law.]

e. "Physician or nurse practitioner" shall mean the physician, or nurse practitioner selected by or assigned to a patient, who has primary responsibility for the treatment and care of the patient for the disease and associated disease states that are the subject of the collaborative drug therapy management.

f. "Written agreement or protocol" shall mean a written document, pursuant to and consistent with any applicable state or federal requirements, that addresses a specific disease or associated disease states and that describes the nature and scope of collaborative drug therapy management to be undertaken by the pharmacists, in collaboration with the participating physician, or nurse practitioner in accordance with the provisions of this section.

2. a. A pharmacist who meets the experience requirements of paragraph b of this subdivision and who is [employed by or otherwise affiliated with a facility] certified by the department to engage in collaborative drug therapy management and who is either employed by or otherwise affiliated with a facility or is participating with a practicing physician or nurse practitioner shall be permitted to enter into a written agreement or protocol with a physician or nurse practitioner authorizing collaborative drug therapy management, subject to the limitations set forth in this section, within the scope of such employment [or], affil-

iation or participation. Only pharmacists so certified may engage in collaborative drug therapy management as defined in this section.

b. A participating pharmacist must:

(i)[(A) have been awarded either a master of science in clinical pharmacy or a doctor of pharmacy degree;

(B)] maintain a current unrestricted license; and

[(C) have a minimum of two years experience, of which at least one year of such experience shall include clinical experience in a health facility, which involves consultation with physicians with respect to drug therapy and may include a residency at a facility involving such consultation; or

(ii)(A) have been awarded a bachelor of science in pharmacy;

(B) maintain a current unrestricted license; and

(C) within the last seven years, have a minimum of three years experience, of which at least one year of such experience shall include clinical experience in a health facility, which involves consultation with physicians with respect to drug therapy and may include a residency at a facility involving such consultation; and

(iii) meet any additional education, experience, or other requirements set forth by the department in consultation with the board]

(ii) satisfy any two of the following criteria:

(A) certification in a relevant area of practice including but not limited to ambulatory care, critical care, geriatric pharmacy, nuclear pharmacy, nutrition support pharmacy, oncology pharmacy, pediatric pharmacy, pharmacotherapy, or psychiatric pharmacy, from a national accrediting body as approved by the department;

(B) postgraduate residency through an accredited postgraduate program requiring at least fifty percent of the experience be in direct patient care services with interdisciplinary terms; or

(C) have provided clinical services to patients for at least one year either:

(I) under a collaborative practice agreement or protocol with a physician, nurse practitioner or facility; or

(II) has documented experience in provision of clinical services to patients for at least one year or one thousand hours, and deemed acceptable to the department upon recommendation of the board of pharmacy.

c. Notwithstanding any provision of law, nothing in this section shall prohibit a licensed pharmacist from engaging in clinical services associated with collaborative drug therapy management, in order to gain experience necessary to qualify under [clause (C) of subparagraph (i) or (ii) of paragraph b of this subdivision] item (II) of clause (C) of subparagraph (ii) of paragraph b of this subdivision, provided that such practice is under the supervision of a pharmacist that currently meets the referenced requirement, and that such practice is authorized under the written agreement or protocol with the physician or nurse practitioner.

d. Notwithstanding any provision of this section, nothing herein shall authorize the pharmacist to diagnose disease. In the event that a treating physician or nurse practitioner may disagree with the exercise of professional judgment by a pharmacist, the judgment of the treating physician or nurse practitioner shall prevail.

[3. The physician who is a party to a written agreement or protocol authorizing collaborative drug therapy management shall be employed by

or otherwise affiliated with the same facility with which the pharmacist is also employed or affiliated.]

4. [The existence of a written agreement or protocol on collaborative drug therapy management and the patient's right to choose to not participate in collaborative drug therapy management shall be disclosed to any patient who is eligible to receive collaborative drug therapy management. Collaborative drug therapy management shall not be utilized unless the patient or the patient's authorized representative consents, in writing, to such management. If the patient or the patient's authorized representative consents, it shall be noted on the patient's medical record. If the patient or the patient's authorized representative who consented to collaborative drug therapy management chooses to no longer participate in such management, at any time, it shall be noted on the patient's medical record. In addition, the existence of the written agreement or protocol and the patient's consent to such management shall be disclosed to the patient's primary physician and any other treating physician or healthcare provider.] A pharmacist who is certified by the department to engage in collaborative drug therapy management may enter into a written collaborative practice agreement or protocol with a physician, nurse practitioner or practice as an independent health care provider or as an employee of a pharmacy or other health care provider.

5. Participation in a written agreement or protocol authorizing collaborative drug therapy management shall be voluntary, and no patient, physician, nurse practitioner, pharmacist, or facility shall be required to participate.

[6. Nothing in this section shall be deemed to limit the scope of practice of pharmacy nor be deemed to limit the authority of pharmacists

and physicians to engage in medication management prior to the effective date of this section and to the extent authorized by law.]

§ 6. Subparagraph (A) of paragraph 15-a of subdivision (i) of section 3216 of the insurance law, as amended by chapter 338 of the laws of 2003, is amended to read as follows:

(A) Every policy which provides medical coverage that includes coverage for physician services in a physician's office and every policy which provides major medical or similar comprehensive-type coverage shall include coverage for the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law: blood glucose monitors and blood glucose monitors for the visually impaired, data management systems, test strips for glucose monitors and visual reading and urine testing strips, insulin, injection aids, cartridges for the visually impaired, syringes, insulin pumps and appurtenances thereto, insulin infusion devices, and oral agents for controlling blood sugar. In addition, the commissioner of the department of health shall provide and periodically update by rule or regulation a list of additional diabetes equipment and related supplies such as are medically necessary for the treatment of diabetes, for which there shall also be coverage. Such policies shall also include coverage for diabetes self-management education to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetic condition, including information on proper diets. Such coverage for self-management education and education relating to diet shall be limited to visits medically necessary upon the diagnosis of diabetes, where a physician diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a

patient's self-management, or where reeducation or refresher education is necessary. Such education may be provided by the physician or other licensed health care provider legally authorized to prescribe under title eight of the education law, or their staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon the referral of a physician, a pharmacist, or other licensed health care provider legally authorized to prescribe under title eight of the education law. Education provided by the certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian may be limited to group settings wherever practicable. Coverage for self-management education and education relating to diet shall also include home visits when medically necessary.

§ 7. Subparagraph (A) of paragraph 7 of subdivision (k) of section 3221 of the insurance law, as amended by chapter 338 of the laws of 2003, is amended to read as follows:

(A) Every group or blanket accident and health insurance policy issued or issued for delivery in this state which provides medical coverage that includes coverage for physician services in a physician's office and every policy which provides major medical or similar comprehensive-type coverage shall include coverage for the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law: blood glucose monitors and blood glucose monitors for the visually impaired, data management systems, test strips for glucose monitors and visual reading and urine testing strips, insulin, injection aids, cartridges for the visually impaired, syringes, insulin pumps and appurtenances thereto, insulin

infusion devices, and oral agents for controlling blood sugar. In addition, the commissioner of the department of health shall provide and periodically update by rule or regulation a list of additional diabetes equipment and related supplies such as are medically necessary for the treatment of diabetes, for which there shall also be coverage. Such policies shall also include coverage for diabetes self-management education to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetic condition, including information on proper diets. Such coverage for self-management education and education relating to diet shall be limited to visits medically necessary upon the diagnosis of diabetes, where a physician diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a patient's self-management, or where reeducation or refresher education is necessary. Such education may be provided by the physician or other licensed health care provider legally authorized to prescribe under title eight of the education law, or their staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon the referral of a physician, a pharmacist, or other licensed health care provider legally authorized to prescribe under title eight of the education law. Education provided by the certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian may be limited to group settings wherever practicable. Coverage for self-management education and education relating to diet shall also include home visits when medically necessary.

§ 8. Paragraph 1 of subdivision (u) of section 4303 of the insurance law, as amended by chapter 338 of the laws of 2003, is amended to read as follows:

(1) A medical expense indemnity corporation or a health service corporation which provides medical coverage that includes coverage for physician services in a physician's office and every policy which provides major medical or similar comprehensive-type coverage shall include coverage for the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law: blood glucose monitors and blood glucose monitors for the visually impaired, data management systems, test strips for glucose monitors and visual reading and urine testing strips, insulin, injection aids, cartridges for the visually impaired, syringes, insulin pumps and appurtenances thereto, insulin infusion devices, and oral agents for controlling blood sugar. In addition, the commissioner of the department of health shall provide and periodically update by rule or regulation a list of additional diabetes equipment and related supplies such as are medically necessary for the treatment of diabetes, for which there shall also be coverage. Such policies shall also include coverage for diabetes self-management education to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetic condition, including information on proper diets. Such coverage for self-management education and education relating to diet shall be limited to visits medically necessary upon the diagnosis of diabetes, where a physician diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a patient's self-management, or where reeducation or refresher education

is necessary. Such education may be provided by the physician or other licensed health care provider legally authorized to prescribe under title eight of the education law, or their staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon the referral of a physician, pharmacist, or other licensed health care provider legally authorized to prescribe under title eight of the education law. Education provided by the certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian may be limited to group settings wherever practicable. Coverage for self-management education and education relating to diet shall also include home visits when medically necessary.

§ 9. Subdivisions (q) and (r) of subdivision 2 of section 365-a of the social services law, subdivision (q) as amended by section 35 of part B of chapter 58 of the laws of 2010 and subdivision (r) as added by section 32 of part C of chapter 58 of the laws of 2008, are amended to read as follows:

(q) diabetes self-management training services for persons diagnosed with diabetes when such services are ordered by a physician, registered physician assistant, registered nurse practitioner, pharmacist, or licensed midwife and provided by a licensed, registered, or certified health care professional, as determined by the commissioner of health, who is certified as a diabetes educator by the National Certification Board for Diabetes Educators, or a successor national certification board, or provided by such a professional who is affiliated with a program certified by the American Diabetes Association, the American Association of Diabetes Educators, the Indian Health Services, or any other national accreditation organization approved by the federal

centers for medicare and medicaid services; provided, however, that the provisions of this paragraph shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this paragraph. Nothing in this paragraph shall be construed to modify any licensure, certification or scope of practice provision under title eight of the education law.

(r) asthma self-management training services for persons diagnosed with asthma when such services are ordered by a physician, registered physician's assistant, registered nurse practitioner, pharmacist, or licensed midwife and provided by a licensed, registered, or certified health care professional, as determined by the commissioner of health, who is certified as an asthma educator by the National Asthma Educator Certification Board, or a successor national certification board; provided, however, that the provisions of this paragraph shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this paragraph. Nothing in this paragraph shall be construed to modify any licensure, certification or scope of practice provision under title eight of the education law.

§ 10. Section 8 of chapter 563 of the laws of 2008, amending the education law and the public health law relating to immunizing agents to be administered to adults by pharmacists, as amended by section 18 of part BB of chapter 56 of the laws of 2020, is amended to read as follows:

§ 8. This act shall take effect on the ninetieth day after it shall have become a law [and shall expire and be deemed repealed July 1, 2022].

§ 11. Section 5 of chapter 116 of the laws of 2012, amending the education law relating to authorizing a licensed pharmacist and certified nurse practitioner to administer certain immunizing agents, as amended by section 19 of part BB of chapter 56 of the laws of 2020, is amended to read as follows:

§ 5. This act shall take effect on the ninetieth day after it shall have become a law[, provided, however, that the provisions of sections one, two and four of this act shall expire and be deemed repealed July 1, 2022 provided, that:

(a) the amendments to subdivision 7 of section 6527 of the education law made by section one of this act shall not affect the repeal of such subdivision and shall be deemed to be repealed therewith;

(b) the amendments to subdivision 7 of section 6909 of the education law, made by section two of this act shall not affect the repeal of such subdivision and shall be deemed to be repealed therewith;

(c) the amendments to subdivision 22 of section 6802 of the education law made by section three of this act shall not affect the repeal of such subdivision and shall be deemed to be repealed therewith; and

(d) the amendments to section 6801 of the education law made by section four of this act shall not affect the expiration of such section and shall be deemed to expire therewith].

§ 12. Section 4 of chapter 274 of the laws of 2013, amending the education law relating to authorizing a licensed pharmacist and certified nurse practitioner to administer meningococcal disease immunizing agents, is amended to read as follows:

§ 4. This act shall take effect on the ninetieth day after it shall have become a law[; provided, that:

(a) the amendments to subdivision 7 of section 6527 of the education law, made by section one of this act shall not affect the expiration and reversion of such subdivision, as provided in section 6 of chapter 116 of the laws of 2012, and shall be deemed to expire therewith; and

(b) the amendments to subdivision 7 of section 6909 of the education law, made by section two of this act shall not affect the expiration and reversion of such subdivision, as provided in section 6 of chapter 116 of the laws of 2012, and shall be deemed to be expire therewith; and

(c) the amendments to subdivision 22 of section 6802 of the education law made by section three of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith].

§ 13. 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 20 of part BB of chapter 56 of the laws of 2020, 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, 2022; 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]. 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.

§ 14. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2021; provided, however, that sections three and four of this act shall take effect on the same date and in the same manner as chapter 110 of the laws of 2020 takes effect; and provided further that the amendments to subdivision 7 of section 6527 of the education law made by section three of this act shall be subject to the expiration and reversion of such subdivision pursuant to section 4 of chapter 110 of the laws of 2020 and shall expire and be deemed repealed therewith; and provided further that the amendments to subdivision 7 of section 6909 of the education law made by section four of this act shall be subject to the expiration and reversion of such subdivision pursuant to section 4 of chapter 110 of the laws of 2020 and shall expire and be deemed repealed therewith.

PART Q

Section 1. Subdivision 1 of section 6502 of the education law, as amended by chapter 599 of the laws of 1996, is amended and two new subdivisions 1-a and 1-b are added to read as follows:

1. [A] <u>Except pursuant to subdivision one-a of this section, a</u> license shall be valid during the life of the holder unless revoked, annulled or suspended by the board of regents [or in the case of physicians, physicians practicing under a limited permit, physician's assistants, specialist's assistants and medical residents, the licensee is stricken from the roster of such licensees by the board of regents on the order of the state board for professional medical conduct in the department of

health. A licensee must register with the department and meet the requirements prescribed in section 3-503 of the general obligations law to practice in this state].

1-a. In the case of physicians, physicians practicing under a limited permit, physician assistants, specialist assistants and medical residents, a license shall be valid during the life of the holder unless:

(i) the licensee is stricken from the roster of such licensees by the board of regents on the order of the state board for professional medical conduct in the department of health; or

(ii) the licensee has failed to register with the department for two consecutive registration periods, in which case the licensee shall be immediately stricken from the roster of such licensees by the board of regents.

1-b. A licensee must register with the department and meet the requirements prescribed in section 3-503 of the general obligations law to practice in this state.

§ 2. Section 6524 of the education law is amended by adding a new subdivision 6-a to read as follows:

(6-a) Fingerprints and criminal history record check: consent to submission of fingerprints for purposes of conducting a criminal history record check. The commissioner shall submit to the division of criminal justice services two sets of fingerprints of applicants for licensure pursuant to this article, and the division of criminal justice services processing fee imposed pursuant to subdivision eight-a of section eight hundred thirty-seven of the executive law and any fee imposed by the federal bureau of investigation. The division of criminal justice services and the federal bureau of investigation shall forward such criminal history record to the commissioner in a timely manner. For the

purposes of this section, the term "criminal history record" shall mean a record of all convictions of crimes and any pending criminal charges maintained on an individual by the division of criminal justice services and the federal bureau of investigation. All such criminal history records sent to the commissioner pursuant to this subdivision shall be confidential pursuant to the applicable federal and state laws, rules and regulations, and shall not be published or in any way disclosed to persons other than the commissioner, unless otherwise authorized by law;

§ 3. Paragraph (c) of subdivision 9 and subdivisions 20, 28 and 31 of section 6530 of the education law, as added by chapter 606 of the laws of 1991, are amended and a new subdivision 51 is added to read as follows:

(c) Having been found guilty in an adjudicatory proceeding of violating a state or federal statute or regulation, pursuant to a final decision or determination, and when no appeal is pending, or after resolution of the proceeding or a complaint alleging a violation of a state or federal statute or regulation by stipulation or agreement, and when the violation would constitute professional misconduct pursuant to this section;

20. Conduct [in the practice of medicine] which evidences moral unfitness to practice medicine;

28. Failing to respond within [thirty] ten days to written communications from the department of health and to make available any relevant records with respect to an inquiry or complaint about the licensee's professional misconduct. The period of [thirty] ten days shall commence on the date when such communication was delivered personally to the licensee. If the communication is sent from the department of health by registered or certified mail, with return receipt requested, to the

address appearing in the last registration, the period of [thirty] ten days shall commence on the date of delivery to the licensee, as indicated by the return receipt;

31. Willfully harassing, abusing, or intimidating a patient [either] or a patient's caregiver or surrogate physically or verbally;

51. Except for good cause shown, failing to notify the department of health within twenty-four hours of having been charged with a crime in any jurisdiction or of any event meeting the definitions of professional misconduct set forth in subdivision nine of this section.

§ 4. Section 6532 of the education law, as added by chapter 606 of the laws of 1991, is amended to read as follows:

§ 6532. Enforcement, administration and interpretation of this article. The board [of] for professional medical conduct and the department of health shall enforce, administer and interpret this article. Before issuing a declaratory ruling pursuant to section two hundred four of the state administrative procedure act with respect to this article, the department of health shall fully consult with the department of education. [Neither the commissioner of education, the board of regents nor the] The commissioner of health may promulgate any rules or regulations concerning this article.

§ 5. Subdivision 4 of section 206 of the public health law, as amended by chapter 602 of the laws of 2007, is amended to read as follows:

4. The commissioner may:

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

(b) require, in writing, the production of any and all relevant documents in the possession or control of an individual or entity subject to an investigation or inquiry under this chapter. Unless a shorter period is specified in such writing, as determined for good cause by the commissioner, the required documents shall be produced no later than ten days after the delivery of the writing. Failure by the subject individual or entity to produce to the department the required documents within the ten day or otherwise specified period shall be a violation or failure within the meaning of paragraph (d) of this subdivision. Each additional day of non-production shall be a separate violation or failure;

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

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

[(d)] (e) 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; and

(f) seek to obtain a warrant based on probable cause that a licensee has committed professional misconduct or a crime from a judicial officer authorized to issue a warrant. Such warrant shall authorize the commissioner and any person authorized by the commissioner to have the authority to inspect all grounds, erections, vehicles, structures, apartments, buildings, places and the contents therein and to remove any books, records, papers, documents, computers, electronic devices and other physical objects.

§ 6. Subdivision 1 of section 230 of the public health law, as amended by chapter 537 of the laws of 1998, is amended to read as follows:

1. A state board for professional medical conduct is hereby created in the department in matters of professional misconduct as defined in sections sixty-five hundred thirty and sixty-five hundred thirty-one of the education law. Its physician members shall be appointed by the commissioner at least eighty-five percent of whom shall be from among nominations submitted by the medical society of the state of New York, the New York state osteopathic society, the New York academy of medicine, county medical societies, statewide specialty societies recognized by the council of medical specialty societies, and the hospital association of New York state. Its lay members shall be appointed by the commissioner with the approval of the governor. The board of regents shall also appoint twenty percent of the members of the board. Not less than sixty-seven percent of the members appointed by the board of regents shall be physicians. Not less than eighty-five percent of the physician members appointed by the board of regents shall be from among nominations submitted by the medical society of the state of New York,

the New York state osteopathic society, the New York academy of medicine, county medical societies, statewide medical societies recognized by the council of medical specialty societies, and the hospital association of New York state. Any failure to meet the percentage thresholds stated in this subdivision shall not be grounds for invalidating any action by or on authority of the board for professional medical conduct or a committee or a member thereof. The board for professional medical conduct shall consist of not fewer than eighteen physicians licensed in the state for at least five years, two of whom shall be doctors of osteopathy, not fewer than two of whom shall be physicians who dedicate a significant portion of their practice to the use of non-conventional medical treatments who may be nominated by New York state medical associations dedicated to the advancement of such treatments, at least one of whom shall have expertise in palliative care, and not fewer than seven lay members. An executive secretary shall be appointed by the chairperson and shall be a licensed physician. Such executive secretary shall not be a member of the board, shall hold office at the pleasure of, and shall have the powers and duties assigned and the annual salary fixed by[, the chairperson. The chairperson shall also assign such secretaries or other persons to the board as are necessary] <u>the commissioner</u>.

§ 7. Clause (C) of subparagraph (iii) of paragraph (a) of subdivision 10 of section 230 of the public health law, as amended by chapter 477 of the laws of 2008, is amended to read as follows:

(C) If the director determines that the matter shall be submitted to an investigation committee, an investigation committee shall be convened [within ninety days of any interview of the licensee]. The director shall present the investigation committee with relevant documentation

including, but not limited to: (1) a copy of the original complaint; (2) the report of the interviewer and the stenographic record if one was taken; (3) the report of any medical or scientific expert; (4) copies of reports of any patient record reviews; and (5) the licensee's submissions.

§ 8. Subparagraph (v) of paragraph (a) of subdivision 10 of section 230 of the public health law, as amended by chapter 477 of the laws of 2008, is amended to read as follows:

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

§ 9. Subparagraphs (i) and (ii) of paragraph (d) of subdivision 10 of section 230 of the public health law, as amended by chapter 477 of the laws of 2008, are amended to read as follows:

(i) A copy of the charges and the notice of the hearing shall be served on the licensee either: (A) personally [by the board] at least thirty days before the hearing[.]; (B) [If personal service cannot be made after due diligence and such fact is certified under oath, a copy of the charges and the notice of hearing shall be served] by registered or certified mail to the licensee's [last known] current residential or practice address [by the board] mailed at least fifteen days before the hearing; (C) by registered or certified mail to the licensee's most recent mailing address pursuant to section sixty-five hundred two of the education law or the licensee's most recent mailing address on file with the department of education pursuant to the notification requirement set forth in subdivision five of such section, mailed at least forty-five days before the hearing; or (D) by first class mail to an attorney, licensed to practice in the state, who has appeared on behalf of the licensee and who has been provided with written authorization of the licensee to accept service, mailed at least thirty days before the hearing.

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

§ 10. Subparagraph (ii) of paragraph (m) of subdivision 10 of section 230 of the public health law, as amended by chapter 606 of the laws of 1991, is amended to read as follows:

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

§ 11. Paragraph (p) of subdivision 10 of section 230 of the public health law, as amended by chapter 599 of the laws of 1996, is amended to read as follows:

(p) Convictions of crimes or administrative violations. Except for good cause shown, a licensee shall notify the department within twenty-four hours of having been charged with a crime in any jurisdiction or of any event meeting the definitions of professional misconduct set forth in subdivision nine of section sixty-five hundred thirty of the education law. In cases of professional misconduct based solely upon a

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

subdivision may be reviewed by the administrative review board for professional medical conduct.

§ 12. Subdivision 12 of section 230 of the public health law, as amended by chapter 627 of the laws of 1996, paragraph (a) as amended by chapter 477 of the laws of 2008 and paragraph (b) as amended by section 3 of part CC of chapter 57 of the laws of 2018, is amended to read as follows:

12. Summary action. (a) Whenever the commissioner, (i) after being presented with information indicating that a licensee is causing, engaging in or maintaining a condition or activity which has resulted in the transmission or suspected transmission, or is likely to lead to the transmission, of communicable disease as defined in the state sanitary code or HIV/AIDS, by the state and/or a local health department and if in the commissioner's opinion it would be prejudicial to the interests of the people to delay action until an opportunity for a hearing can be provided in accordance with the prehearing and hearing provisions of this section; [or] (ii) after requiring that a licensee produce documents in accordance with subdivision four of section two hundred six of this chapter, and such licensee has failed to produce the required documents within ten days, or within such shorter period as may have been specified in the commissioner's written demand for documents; or (iii) after an investigation and a recommendation by a committee on professional conduct of the state board for professional medical conduct, based upon a determination that a licensee is causing, engaging in or maintaining a condition or activity which in the commissioner's opinion [constitutes an imminent danger] presents a risk to the health of the people, and that it therefore appears to be prejudicial to the interests of the people to delay action until an opportunity for a hearing can be

provided in accordance with the prehearing and hearing provisions of this section; the commissioner may order the licensee, by written notice, to discontinue such dangerous condition or activity or take certain action immediately and for a period of [ninety] one hundred twenty days from the date of service of the order. Within [ten] thirty days from the date of service of the said order, the state board for professional medical conduct shall commence and regularly schedule such hearing proceedings as required by this section, provided, however, that the hearing shall be completed within [ninety] one hundred twenty days of the date of service of the order. To the extent that the issue of [imminent danger] risk of the health of the people can be proven without the attorney representing the office of professional medical conduct putting in its entire case, the committee of the board shall first determine whether by a preponderance of the evidence the licensee is causing, engaging in or maintaining a condition or activity which [constitutes an imminent danger] presents a risk to the health of the people. The attorney representing the office of professional medical conduct shall have the burden of going forward and proving by a preponderance of the evidence that the licensee's condition, activity or practice [constitutes an imminent danger] presents a risk to the health of the people. The licensee shall have an opportunity to be heard and to present proof. When both the office and the licensee have completed their cases with respect to the question of [imminent danger] risk to the health of the people, the committee shall promptly make a recommendation to the commissioner on the issue of [imminent danger] risk to the health of the people and determine whether the summary order should be left in effect, modified or vacated, and continue the hearing on all the remaining charges, if any, in accordance with paragraph (f) of subdivi-

sion ten of this section. Within ten days of the committee's recommendation, the commissioner shall determine whether or not to adopt the committee's recommendations, in whole or in part, and shall leave in effect, modify or vacate his summary order. The state board for professional medical conduct shall make every reasonable effort to avoid any delay in completing and determining such proceedings. If, at the conclusion of the hearing, (i) the hearing committee of the board finds the licensee guilty of one or more of the charges which are the basis for the summary order, (ii) the hearing committee determines that the summary order continue, and (iii) the ninety day term of the order has not expired, the summary order shall remain in full force and effect until a final decision has been rendered by the committee or, if review is sought, by the administrative review board. A summary order shall be public upon issuance.

(b) When a licensee has pleaded or been found guilty or convicted of committing an act constituting a felony under New York state law or federal law, or the law of another jurisdiction which, if committed within this state, would have constituted a felony under New York state law, or when a licensee has been charged with committing an act constituting a felony under New York state or federal law or the law of another jurisdiction, where the licensee's alleged conduct, which, if committed within this state, would have constituted a felony under New York state law, and [in the commissioner's opinion the licensee's alleged conduct constitutes an imminent danger] <u>where the licensee's alleged conduct may present a risk</u> to the health of the people, or when the duly authorized professional disciplinary agency of another jurisdiction has made a finding substantially equivalent to a finding that the practice of medicine by the licensee in that jurisdiction [constitutes an immi-

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

§ 13. Paragraph (a) of subdivision 1 of section 2803-e of the public health law, as amended by chapter 294 of the laws of 1985, is amended to read as follows:

(a) Hospitals and other facilities approved pursuant to this article shall make a report or cause a report to be made within thirty days of the occurrence of any of the following: the suspension, restriction, termination or curtailment of the training, employment, association or professional privileges or the denial of the certification of completion of training of an individual licensed pursuant to the provisions of title eight of the education law or of a medical resident with such facility for reasons related in any way to alleged mental or physical impairment, incompetence, malpractice or misconduct or impairment of patient safety or welfare; the voluntary or involuntary resignation or withdrawal of association or of privileges with such facility to avoid the imposition of disciplinary measures; notification by the hospital or facility, to any entity providing personnel to perform professional services to such hospital or facility, that the entity may not assign a particular individual to provide such services to the hospital or facility, for reasons related in any way to alleged mental or physical impairment, incompetence, malpractice or misconduct or impairment of patient safety or welfare; or the receipt of information which indicates that any professional licensee or medical resident has been convicted of a crime; the denial of staff privileges to a physician if the reasons stated for such denial are related to alleged mental or physical impairment, incompetence, malpractice, misconduct or impairment of patient safety or welfare.

§ 14. Paragraphs (n), (p) and (q) of subdivision 1 of section 2995-a of the public health law, as added by chapter 542 of the laws of 2000, are amended and three new paragraphs (r), (s) and (t) are added to read as follows:

(n) (i) the location of the licensee's primary practice setting identified as such; [and]

(ii) [the names of any licensed physicians with whom the licensee shares a group practice, as defined in subdivision five of section two hundred thirty-eight of this chapter] hours of operation of the licensee's primary practice setting;

(iii) availability of assistive technology at the licensee's primary practice setting; and

(iv) whether the licensee is accepting new patients;

(p) whether the licensee participates in the medicaid or medicare program or any other state or federally financed health insurance program; [and]

(q) health care plans with which the licensee has contracts, employment, or other affiliation[.] provided that the reporting and accuracy of such information shall not be the responsibility of the physician, but shall be included and updated by the department utilizing provider network participation information, or other reliable sources of information submitted by the health care plans;

(r) the physician's website and social media accounts;

(s) the names of any licensed physicians with whom the licensee shares a group practice, as defined in subdivision five of section two hundred thirty-eight of this chapter; and

(t) workforce research and planning information as determined by the commissioner.

§ 15. Section 2995-a of the public health law is amended by adding a new subdivision 1-b to read as follows:

1-b. (a) For the purposes of this section, a physician licensed and registered to practice in this state may authorize a designee to regis-

ter, transmit, enter or update information on his or her behalf, provided that:

(i) the designee so authorized is employed by the physician or the same professional practice or is under contract with such practice;

(ii) the physician takes reasonable steps to ensure that such designee is sufficiently competent in the profile requirements;

(iii) the physician remains responsible for ensuring the accuracy of the information provided and for any failure to provide accurate information; and

(iv) the physician shall notify the department upon terminating the authorization of any designee, in a manner determined by the department.

(b) The commissioner shall grant access to the profile in a reasonably prompt manner to designees authorized by physicians and establish a mechanism to prevent designees terminated pursuant to subparagraph (iv) of paragraph (a) of this subdivision from accessing the profile in a reasonably prompt manner following notification of termination.

§ 16. Subdivision 4 of section 2995-a of the public health law, as amended by section 3 of part A of chapter 57 of the laws of 2015, is amended to read as follows:

4. Each physician shall periodically report to the department on forms and in the time and manner required by the commissioner any other information as is required by the department for the development of profiles under this section which is not otherwise reasonably obtainable. In addition to such periodic reports and providing the same information, each physician shall update his or her profile information within the six months prior to [the expiration date of such physician's registration period] submission of the re-registration application, as a condition of registration renewal [under article one hundred thirty-one]

pursuant to section sixty-five hundred twenty-four of the education law. Except for optional information provided and information required under subparagraph (iv) of paragraph (n) and paragraphs (q) and (t) of subdivision one of this section, physicians shall notify the department of any change in the profile information within thirty days of such change.

§ 17. Subdivision 6 of section 2995-a of the public health law, as added by chapter 542 of the laws of 2000, is amended to read as follows:

6. A physician may elect to have his or her profile omit certain information provided pursuant to paragraphs (k), (l), (m), [(n) and (q)] (r) and (s) of subdivision one of this section. Information provided pursuant to paragraph (t) of subdivision one of this section shall be omitted from a physician's profile and shall be exempt from disclosure under article six of the public officers law. In collecting information for such profiles and disseminating the same, the department shall inform physicians that they may choose not to provide such information required pursuant to paragraphs (k), (l), (m), [(n) and (q)] (r) and (s) of subdivision one of this section.

§ 18. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2021; provided, however, that the amendments to paragraph (a) of subdivision 10 of section 230 of the public health law made by sections seven and eight of this act shall not affect the expiration of such paragraph and shall be deemed to expire therewith; and further provided that sections fourteen, fifteen, sixteen and seventeen of this act shall take effect on the one hundred eightieth day after it shall have become a law.

PART R

Section 1. Section 63 of the civil rights law, as amended by chapter 253 of the laws of 2014, is amended to read as follows:

§ 63. Order. If the court to which the petition is presented is satisfied thereby, or by the affidavit and certificate presented therewith, that the petition is true, and that there is no reasonable objection to the change of name proposed, and if the petition be to change the name of an infant, that the interests of the infant will be substantially promoted by the change, the court shall make an order authorizing the petitioner to assume the name proposed. The order shall further recite the date and place of birth of the applicant and, if the applicant was born in the state of New York, such order shall set forth the number of [his] the applicant's birth certificate or that no birth certificate is available. The order shall be directed to be entered and the papers on which it was granted to be filed [prior to the publication hereinafter directed] in the clerk's office of the county in which the petitioner resides if he be an individual, or in the office of the clerk of the civil court of the city of New York if the order be made by that court. [Such order shall also direct the publication, at least once, within sixty days after the making of the order, in a designated newspaper in the county in which the order is directed to be entered and if the petition is made by a person subject to the provisions of subdivision two of section sixty-two of this article, in a designated newspaper in any county wherein such person was convicted if different from the county in which the order is otherwise directed to be entered, of a notice in substantially the following form: Notice is hereby given that an order entered by the ..... court,..... county, on the ..... day of....., bearing Index Number....., a copy of which may be examined at the office of the clerk, located at ....., in room

number....., grants me the right to assume the name of ..... The city and state of my present address are .....; the month and year of my birth are .....; the place of my birth is .....; my present name is .....]

§ 2. Section 64 of the civil rights law, as amended by chapter 258 of the laws of 2006, and the closing paragraph as separately amended by chapters 258, 320 and 481 of the laws of 2006, is amended to read as follows:

§ 64. Effect. If the order [shall be fully complied with, and within ninety days after the making of the order, an affidavit of the publication thereof shall be filed in the office in which the order] is entered, the petitioner shall be known by the name which is thereby authorized to be assumed. If the surname of a parent be changed as provided in this article, any minor child of such parent at the time of such change may thereafter assume such changed surname.

[Upon compliance with the order and the filing of the affidavit of the publication, as provided in this section, the clerk of the court in which the order has been entered shall certify that the order has been complied with; and, if] (1) If the petition states that the petitioner stands convicted of a violent felony offense as defined in section 70.02 of the penal law or a felony defined in article one hundred twenty-five of such law or any of the following provisions of such law sections 130.25, 130.30, 130.40, 130.45, 255.25, 255.26, 255.27, article two hundred sixty-three, 135.10, 135.25, 230.05, 230.06, subdivision two of section 230.30 or 230.32, [such] the clerk [(1)] of the court in which the order has been entered shall deliver, by first class mail, a copy of such certified order to the division of criminal justice services at its

office in the county of Albany and (2) [upon the clerk of the court reviewing the petitioner's application for name change and subsequent in-court inquiry, may, in the clerk's discretion, deliver, by first class mail, the petitioner's new name with such certified order to the court of competent jurisdiction which imposed the orders of support. Such certification shall appear on the original order and on any certified copy thereof and shall be entered in the clerk's minutes of the proceeding] if the petition states that the petitioner is responsible for spousal support or child support obligations pursuant to court order, upon review of the petitioner's application for name change and subsequent in-court inquiry, the court may, in its discretion, order the petitioner to deliver by first class mail, the petitioner's new name with such certified order to the court of competent jurisdiction which imposed the orders of support. Such certification shall appear on the original order and on any certified copy thereof and shall be entered in the court's minutes of the proceeding.

§ 3. Section 64-a of the civil rights law, as amended by chapter 241 of the laws of 2015, is amended to read as follows:

§ 64-a. [Exemption from publication requirements] Sealing name change papers. 1. If the court shall find that [the publication] open record of an applicant's change of name would jeopardize such applicant's personal safety, based on totality of the circumstances [the provisions of sections sixty-three and sixty-four of this article requiring publication shall be waived and shall be inapplicable. Provided, however, the court shall not deny such waiver soley on the basis that the applicant lacks specific instances of or a personal history of threat to personal safety. The], the court shall order the records of such change of name proceeding [to] be sealed, to be opened only by order of the court for

good cause shown or at the request of the applicant. For the purposes of this section, "totality of the circumstances" shall include, but not be limited to, a consideration of the risk of violence or discrimination against the applicant. The court shall not deny such sealing request solely on the basis that the applicant lacks specific instances of or a personal history of threat to personal safety.

2. Notwithstanding any other provision of law, pending such a finding in subdivision one of this section where an applicant seeks relief under this section, the court shall immediately order the applicant's current name, proposed new name, residential and business addresses, telephone numbers, and any other information contained in any pleadings or papers submitted to the court to be safeguarded and sealed in order to prevent their inadvertent or unauthorized use or disclosure while the matter is pending.

§ 4. The civil rights law is amended by adding a new article 6-A to read as follows:

ARTICLE 6-A

CHANGE OF SEX DESIGNATION OR GENDER DESIGNATION

Section 67. Petition to change sex designation or gender designation.

67-a. Order.

67-b. Sealing change of sex designation or gender designation papers.

67-c. Effect on government issued identity documents.

§ 67. Petition to change sex designation or gender designation. 1. A petition for leave to change sex designation or gender designation may be made by a resident of the state to the county court of the county or the supreme court in the county in which such resident resides, or, if such resident resides in the city of New York, either to the supreme

court or to any branch of the civil court of the city of New York, in any county of the city of New York. The petition to change the sex designation or gender designation of an infant may be made by the infant through either of such infant's parents, or by such infant's general guardian or by the guardian of such infant's person.

2. When an individual petitions the court to recognize their gender identity or to amend the sex designation or gender designation on an identity document, the court shall issue such an order upon receipt of an affidavit from such individual attesting to their gender identity or reason for the change. No additional medical evidence shall be required to grant such request. No such order shall be required to amend an identity document issued within New York state. No such order shall be required to otherwise recognize the gender of an individual and treat them consistent with their gender identity within New York state or under New York state law.

3. Such request may be made simultaneously with a petition for change of name pursuant to section sixty or sixty-five of this chapter or on its own.

§ 67-a. Order. If the court to which the petition is presented is satisfied thereby, or by the affidavit and certificate presented therewith, and that there is no reasonable objection to the change of sex designation or gender designation proposed, and if the petition is to change the sex designation or gender designation of an infant, that the interests of the infant will be substantially promoted by the change, the court shall make an order authorizing the petitioner to assume the sex designation or gender designation proposed.

§ 67-b. Sealing change of sex designation or gender designation papers. 1. Upon request of the applicant, the court shall order the

records of such change of sex designation or gender designation proceeding to be sealed, to be opened only by order of the court for good cause shown or at the request of the applicant.

2. Notwithstanding any other provision of law, pending such a finding in subdivision one of this section where an applicant seeks relief under this section, the court shall immediately order the applicant's current name, sex designation, proposed new sex designation or gender designation, residential and business addresses, telephone numbers, and any other information contained in any pleadings or papers submitted to the court to be safeguarded and sealed in order to prevent their inadvertent or unauthorized use or disclosure while the matter is pending.

§ 67-c. Effect on government issued identity documents. Any state agency that maintains a system or issues an identity document requiring a sex designation or gender designation that, due to federal law or systems processing requirements, is unable to process or change such record or document consistent with an order issued pursuant to this section shall make reasonable efforts to otherwise accommodate such request.

§ 5. 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 S

Section 1. Section 11 of chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care

allowances for certified home health agencies, as amended by section 3 of part E of chapter 57 of the laws of 2019, is amended to read as follows:

§ 11. This act shall take effect immediately and:

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

(b) sections four through ten shall expire on June 30, [2021] 2023, and

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

§ 2. Subdivision (a) of section 40 of part B of chapter 109 of the laws of 2010, amending the social services law relating to transportation costs, as amended by section 5 of part E of chapter 57 of the laws of 2019, is amended to read as follows:

(a) sections two, three, three-a, three-b, three-c, three-d, three-e and twenty-one of this act shall take effect July 1, 2010; sections fifteen, sixteen, seventeen, eighteen and nineteen of this act shall take effect January 1, 2011; [and provided further that section twenty of this act shall be deemed repealed ten years after the date the contract entered into pursuant to section 365-h of the social services law, as amended by section twenty of this act, is executed; provided that the commissioner of health shall notify the legislative bill drafting commission upon the execution of the contract entered into pursuant to section 367-h of the social services law 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. Subdivision 5-a of section 246 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 12 of part E of chapter 57 of the laws of 2019, is amended to read as follows:

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

§ 4. Section 64-b of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 13 of part E of chapter 57 of the laws of 2019, is amended to read as follows:

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

and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017 and on and after April 1, 2017 through March 31, 2019, and on and after April 1, 2019 through March 31, 2021, and on and after April 1, 2021 through March 31, 2023.

§ 5. Section 4-a of part A of chapter 56 of the laws of 2013, amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates, as amended by section 14 of part E of chapter 57 of the laws of 2019, is amended to read as follows:

§ 4-a. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law, section 21 of chapter 1 of the laws of 1999, or any other contrary provision of law, in determining rates of payments by state governmental agencies effective for services provided on and after January 1, 2017 through March 31, [2021] 2023, for inpatient and outpatient services provided by general hospitals, for inpatient services and adult day health care outpatient services provided by residential health care facilities pursuant to article 28 of the public health law, except for residential health care facilities or units of such facilities providing services primarily to children under twenty-one years of age, for home health care services provided pursuant to article 36 of the public health law by certified home health agencies, long term home health care programs and AIDS home care programs, and for personal care services provided pursuant to section 365-a of the social services law, the commissioner of health shall apply no greater than zero trend factors attributable to the 2017, 2018, 2019, 2020, [and] 2021, 2022 and 2023 calendar years in accordance with paragraph (c) of subdivision 10 of section 2807-c of the public health law, provided,

however, that such no greater than zero trend factors attributable to such 2017, 2018, 2019, 2020, [and] 2021, 2022 and 2023 calendar years shall also be applied to rates of payment provided on and after January 1, 2017 through March 31, [2021] 2023 for personal care services provided in those local social services districts, including New York city, whose rates of payment for such services are established by such local social services districts pursuant to a rate-setting exemption issued by the commissioner of health to such local social services districts in accordance with applicable regulations; and provided further, however, that for rates of payment for assisted living program services provided on and after January 1, 2017 through March 31, [2021] 2023, such trend factors attributable to the 2017, 2018, 2019, 2020, [and] 2021, 2022 and 2023 calendar years shall be established at no greater than zero percent.

§ 6. Subdivision 2 of section 246 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 17 of part E of chapter 57 of the laws of 2019, is amended to read as follows:

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

through March 31, 2017 and on and after April 1, 2017 through March 31, 2019, and on and after April 1, 2019 through March 31, 2021, and on and after April 1, 2021 through March 31, 2023;

§ 7. 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 11 of part BB of chapter 56 of the laws of 2020, 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, [2021] 2024.

§ 8. Section 5 of chapter 517 of the laws of 2016, amending the public health law relating to payments from the New York state medical indemnity fund, as amended by section 18 of part Y of chapter 56 of the laws of 2020, is amended to read as follows:

§ 5. This act shall take effect on the forty-fifth day after it shall have become a law, provided that the amendments to subdivision 4 of section 2999-j of the public health law made by section two of this act shall take effect on June 30, 2017 and shall expire and be deemed repealed December 31, [2021] 2022.

§ 9. Subdivision 1 of section 2999-aa of the public health law, as amended by chapter 80 of the laws of 2017, is amended to read as follows:

1. In order to promote improved quality and efficiency of, and access to, health care services and to promote improved clinical outcomes to the residents of New York, it shall be the policy of the state to encourage, where appropriate, cooperative, collaborative and integrative arrangements including but not limited to, mergers and acquisitions

among health care providers or among others who might otherwise be competitors, under the active supervision of the commissioner. To the extent such arrangements, or the planning and negotiations that precede them, might be anti-competitive within the meaning and intent of the state and federal antitrust laws, the intent of the state is to supplant competition with such arrangements under the active supervision and related administrative actions of the commissioner as necessary to accomplish the purposes of this article, and to provide state action immunity under the state and federal antitrust laws with respect to activities undertaken by health care providers and others pursuant to this article, where the benefits of such active supervision, arrangements and actions of the commissioner outweigh any disadvantages likely to result from a reduction of competition. The commissioner shall not approve an arrangement for which state action immunity is sought under this article without first consulting with, and receiving a recommendation from, the public health and health planning council. No arrangement under this article shall be approved after December thirty-first, two thousand [twenty] twenty-four.

§ 10. Section 3 of part D of chapter 56 of the laws of 2014, amending the education law relating to the nurse practitioners modernization act, is amended to read as follows:

§ 3. This act shall take effect on the first of January after it shall have become a law and shall expire June 30 of the [sixth] twelfth year after it shall have become a law, when upon such date the provisions of this act shall be deemed repealed; provided, however, 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 is authorized and directed to be made and completed on or before such effective date.

§ 11. Subparagraph (vi) of paragraph (b) of subdivision 2 of section 2807-d of the public health law, as amended by section 9 of part E of chapter 57 of the laws of 2019, is amended to read as follows:

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

gross receipts received on or after April first, two thousand fifteen through March thirty-first, two thousand seventeen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand seventeen through March thirty-first, two thousand nineteen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand nineteen through March thirty-first, two thousand twenty-one such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand twenty-one through March thirty-first, two thousand twenty-three such assessment shall be six percent.

§ 12. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2021.

PART T

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 X of chapter 57 of the laws of 2018, is amended to read as follows:

§ 3. This act shall take effect immediately; and shall expire and be deemed repealed June 30, [2021] 2024.

§ 2. This act shall take effect immediately.

PART U

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

§ 4. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2016; provided, however, that sections one and two of this act shall expire and be deemed repealed on March 31, [2021] 2026.

§ 2. This act shall take effect immediately.

PART V

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 U of chapter 57 of the laws of 2018, is amended to read as follows:

§ 2. This act shall take effect immediately and shall expire and be deemed repealed March 31, [2021] 2024.

§ 2. This act shall take effect immediately.

PART W

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 V of chapter 57 of the laws of 2018, is amended to read as follows:

§ 7. This act shall take effect immediately and shall expire March 31, [2021] 2024 when upon such date the provisions of this act shall be deemed repealed.

§ 2. This act shall take effect immediately.

PART X

Section 1. Notwithstanding the provisions of subdivisions (b) and (e) of section 7.17 and section 41.55 of the mental hygiene law or any other law to the contrary, the office of mental health is authorized in state fiscal year 2021-22 to close, consolidate, reduce, transfer or otherwise redesign services of hospitals, other facilities and programs operated by the office of mental health, and to implement significant service reductions and reconfigurations according to this section as shall be determined by the commissioner of mental health to be necessary for the cost-effective and efficient operation of such hospitals, other facilities and programs. Any transfers of capacity or any resulting transfer of functions shall be authorized to be made by the commissioner of mental health and any transfer of personnel upon such transfer of capacity or transfer of functions shall be accomplished in accordance with the provisions of subdivision 2 of section 70 of the civil service law.

§ 2. This act shall take effect immediately and shall expire March 31, 2022 when upon such date the provisions of this act shall be deemed repealed.

PART Y

Section 1. Section 19.07 of the mental hygiene law, as added by chapter 223 of the laws of 1992, subdivisions (a) and (g) as amended by chapter 271 of the laws of 2010, subdivisions (b) and (c) as amended by chapter 281 of the laws of 2019, subdivision (d) as amended by section 5 of part I of chapter 58 of the laws of 2005, subdivision (e) as amended by chapter 558 of the laws of 1999, subdivision (f) as added by chapter 383 of the laws of 1998, subdivision (h) as amended by section 118-f of subpart B of part C of chapter 62 of the laws of 2011, subdivision (i) as amended by section 31-a of part AA of chapter 56 of the laws of 2019, subdivision (j) as amended by chapter 146 of the laws of 2014, subdivision (k) as added by chapter 40 of the laws of 2014, subdivision (l) as added by chapter 323 of the laws of 2018 and subdivision (m) as added by chapter 493 of the laws of 2019, is amended to read as follows:

§ 19.07 Office of [alcoholism and substance abuse services] <u>addiction services and supports</u>; scope of responsibilities.

(a) The office of [alcoholism and substance abuse services] <u>addiction services and supports</u> is charged with the responsibility for assuring the development of comprehensive plans, programs, and services in the areas of research, prevention, care, treatment, rehabilitation, including relapse prevention and recovery maintenance, education, and training of persons who [abuse or are dependent on alcohol and/or substances] <u>have or are at risk of an addictive disorder</u> and their families. <u>The</u>

term addictive disorder shall include gambling disorder education, prevention and treatment consistent with section 41.57 of this chapter. Such plans, programs, and services shall be developed with the cooperation of the office, the other offices of the department where appropriate, local governments, consumers and community organizations and entities. The office shall provide appropriate facilities and shall encourage the provision of facilities by local government and community organizations and entities. [The office is also responsible for developing plans, programs and services related to compulsive gambling education, prevention and treatment consistent with section 41.57 of this chapter.]

(b) The office of [alcoholism and substance abuse services] addiction services and supports shall advise and assist the governor in improving services and developing policies designed to meet the needs of persons who suffer from or are at risk of an addictive disorder and their families, and to encourage their rehabilitation, maintenance of recovery, and functioning in society.

(c) The office of [alcoholism and substance abuse services] addiction services and supports shall have the responsibility for seeing that persons who suffer from or are at risk of an addictive disorder and their families are provided with addiction services, care and treatment, and that such services, care, treatment and rehabilitation is of high quality and effectiveness, and that the personal and civil rights of persons seeking and receiving addiction services, care, treatment and rehabilitation are adequately protected.

(d) The office of [alcoholism and substance abuse services] addiction services and supports shall foster programs for the training and development of persons capable of providing the foregoing services, including

but not limited to a process of issuing, either directly or through contract, licenses, credentials, certificates or authorizations for [alcoholism and substance abuse counselors or gambling] addiction [counselors] professionals in accordance with the following:

(1) The office shall establish minimum qualifications [for counselors] and a definition of the practice of the profession of an addiction professional in all phases of delivery of services to persons and their families who are suffering from [alcohol and/or substance abuse and/or chemical dependence and/or compulsive gambling that shall include] or are at risk of an addictive disorder including, but not be limited to, completion of approved courses of study or equivalent on-the-job experience in [alcoholism and substance abuse counseling and/or counseling of compulsive gambling] or at risk of addiction disorder services.

(i) The office shall establish procedures for issuing, directly or through contract, licenses, credentials, certificates or authorizations to [counselors] addiction professionals who meet minimum qualifications, including the establishment of appropriate fees, and shall further establish procedures to suspend, revoke, or annul such licenses, credentials, certificates or authorizations for good cause. Such procedures shall be promulgated by the commissioner by rule or regulation.

(ii) The commissioner shall establish [a credentialing] an addiction professionals board which shall provide advice concerning the licensing, credentialing, certification or authorization process.

(iii) The commissioner shall establish fees for the education, training, licensing, credentialing, certification or authorization of addiction professionals.

(2) The establishment, with the advice of the advisory council on alcoholism and substance abuse services, of minimum qualifications for

[counselors] addiction professionals in all phases of delivery of services to those suffering from [alcoholism, substance and/or chemical abuse and/or dependence and/or compulsive gambling] or at risk of addictive disorders and their families that shall include, but not be limited to, completion of approved courses of study or equivalent on-the-job experience in [counseling for alcoholism, substance and/or chemical abuse and/or dependence] addiction disorder services and/or [compulsive] gambling disorder services, and establish appropriate fees, issue licenses, credentials, certificates or authorizations to [counselors] addiction professionals who meet minimum qualifications and suspend, revoke, or annul such licenses, credentials, certificates or authorizations for good cause in accordance with procedures promulgated by the commissioner by rule or regulation.

(3) For the purpose of this title, the term "addiction professional", including "credentialed alcoholism and substance abuse counselor" or "C.A.S.A.C.", means an official designation identifying an individual as one who holds a currently registered and valid license, credential, certificate or authorization issued or approved by the office of [alcoholism and substance abuse services] addiction services and supports pursuant to this section which documents an individual's qualifications to provide [alcoholism and substance abuse counseling] addiction disorder services. The term "gambling addiction [counselor"] professional" means an official designation identifying an individual as one who holds a currently registered and valid license, credential, certificate or authorization issued by the office of [alcoholism and substance abuse services] addiction services and supports pursuant to this section which documents an individual's qualifications to provide [compulsive] gambling [counseling] disorder services.

(i) No person shall use the title [credentialed alcoholism and substance abuse counselor or "C.A.S.A.C." or gambling addiction counselor] "addiction professional" or the title given to any licenses, credentials, certificates or authorizations issued by the office unless authorized [pursuant to] by the commissioner in accordance with this title.

(ii) Failure to comply with the requirements of this section shall constitute a violation as defined in the penal law.

(4) All persons holding previously issued and valid alcoholism or substance abuse counselor credentials issued by the office or an entity designated by the office, including a credentialed alcoholism and substance abuse counselor, certified prevention specialist, credentialed prevention professional, credentialed problem gambling counselor, gambling specialty designation, certified recovery peer advocate, on the effective date of amendments to this section shall be deemed [C.A.S.A.C. designated] an addiction professional consistent with their experience and education.

(e) Consistent with the requirements of subdivision (b) of section 5.05 of this chapter, the office shall carry out the provisions of article thirty-two of this chapter as such article pertains to regulation and quality control of [chemical dependence] addiction disorder services, including but not limited to the establishment of standards for determining the necessity and appropriateness of care and services provided by [chemical dependence] addiction disorder providers of services. In implementing this subdivision, the commissioner, in consultation with the commissioner of health, shall adopt standards including necessary rules and regulations including but not limited to those for determining the necessity or appropriate level of admission, controlling

the length of stay and the provision of services, and establishing the methods and procedures for making such determination.

(f) The office of [alcoholism and substance abuse services] addiction services and supports shall develop a list of all agencies throughout the state which are currently certified by the office and are capable of and available to provide evaluations in accordance with section sixty-five-b of the alcoholic beverage control law so as to determine need for treatment pursuant to such section and to assure the availability of such evaluation services by a certified agency within a reasonable distance of every court of a local jurisdiction in the state. Such list shall be updated on a regular basis and shall be made available to every supreme court law library in this state, or, if no supreme court law library is available in a certain county, to the county court library of such county. The commissioner may establish an annual fee for inclusion on such list.

(g) The office of [alcoholism and substance abuse services] addiction services and supports shall develop and maintain a list of the names and locations of all licensed agencies and [alcohol and substance abuse] addiction professionals, as defined in paragraphs (a) and (b) of subdivision one of section eleven hundred ninety-eight-a of the vehicle and traffic law, throughout the state which are capable of and available to provide an assessment of, and treatment for, [alcohol and substance abuse and dependency] addiction disorders. Such list shall be provided to the chief administrator of the office of court administration and the commissioner of motor vehicles. Persons who may be aggrieved by an agency decision regarding inclusion on the list may request an administrative appeal in accordance with rules and regulations of the office. The commissioner may establish an annual fee for inclusion on such list.

(h) The office of [alcoholism and substance abuse services] addiction services and supports shall monitor programs providing care and treatment to inmates in correctional facilities operated by the department of corrections and community supervision who have a history of [alcohol or substance abuse or dependence] an addiction disorder. The office shall also develop guidelines for the operation of [alcohol and substance abuse treatment programs] addiction disorder services in such correctional facilities in order to ensure that such programs sufficiently meet the needs of inmates with a history of [alcohol or substance abuse or dependence] an addiction disorder and promote the successful transition to treatment in the community upon release. No later than the first day of December of each year, the office shall submit a report regarding the adequacy and effectiveness of alcohol and substance abuse treatment programs operated by the department of corrections and community supervision to the governor, the temporary president of the senate, the speaker of the assembly, the chairman of the senate committee on crime victims, crime and correction, and the chairman of the assembly committee on correction.

(i) The office of [alcoholism and substance abuse services] addiction services and supports shall periodically, in consultation with the state director of veterans' services: (1) review the programs operated by the office to ensure that the needs of the state's veterans who served in the U.S. armed forces and who are recovering from [alcohol and/or substance abuse] an addiction disorder are being met and to develop improvements to programs to meet such needs; and (2) in collaboration with the state director of veterans' services and the commissioner of the office of mental health, review and make recommendations to improve programs that provide treatment, rehabilitation, relapse prevention, and

recovery services to veterans who have served in a combat theatre or combat zone of operations and have a co-occurring mental health and [alcoholism or substance abuse] addiction disorder.

(j) The office, in consultation with the state education department, shall identify or develop materials on problem gambling among school-age youth which may be used by school districts and boards of cooperative educational services, at their option, to educate students on the dangers and consequences of problem gambling as they deem appropriate. Such materials shall be available on the internet website of the state education department. The internet website of the office shall provide a hyperlink to the internet page of the state education department that displays such materials.

(k) Heroin and opioid addiction awareness and education program. The commissioner, in cooperation with the commissioner of the department of health, shall develop and conduct a public awareness and educational campaign on heroin and opioid addiction. The campaign shall utilize public forums, social media and mass media, including, but not limited to, internet, radio, and print advertising such as billboards and posters and shall also include posting of materials and information on the office website. The campaign shall be tailored to educate youth, parents, healthcare professionals and the general public regarding: (1) the risks associated with the abuse and misuse of heroin and opioids; (2) how to recognize the signs of addiction; and (3) the resources available for those needing assistance with heroin or opioid addiction. The campaign shall further be designed to enhance awareness of the opioid overdose prevention program authorized pursuant to section thirty-three hundred nine of the public health law and the "Good Samaritan law" established pursuant to sections 220.03 and 220.78 of the penal law

and section 390.40 of the criminal procedure law, and to reduce the stigma associated with addiction.

(l) The office of [alcoholism and substance abuse services] addiction services and supports, in consultation with the state education department, shall develop or utilize existing educational materials to be provided to school districts and boards of cooperative educational services for use in addition to or in conjunction with any drug and alcohol related curriculum regarding the misuse and abuse of alcohol, tobacco, prescription medication and other drugs with an increased focus on substances that are most prevalent among school aged youth as such term is defined in section eight hundred four of the education law. Such materials shall be age appropriate for school age children, and to the extent practicable, shall include information or resources for parents to identify the warning signs and address the risks of substance [abuse] misuse and addiction.

(m) (1) The office shall report on the status and outcomes of initiatives created in response to the heroin and opioid epidemic to the temporary president of the senate, the speaker of the assembly, the chairs of the assembly and senate committees on alcoholism and drug abuse, the chair of the assembly ways and means committee and the chair of the senate finance committee.

(2) Such reports shall include, to the extent practicable and applicable, information on:

(i) The number of individuals enrolled in the initiative in the preceding quarter;

(ii) The number of individuals who completed the treatment program in the preceding quarter;

(iii) The number of individuals discharged from the treatment program in the preceding quarter;

(iv) The age and sex of the individuals served;

(v) Relevant regional data about the individuals;

(vi) The populations served; and

(vii) The outcomes and effectiveness of each initiative surveyed.

(3) Such initiatives shall include opioid treatment programs, crisis detoxification programs, 24/7 open access centers, adolescent club houses, family navigator programs, peer engagement specialists, recovery community and outreach centers, regional addiction resource centers and the state implementation of the federal opioid state targeted response initiatives.

(4) Such information shall be provided quarterly, beginning no later than July first, two thousand nineteen.

§ 2. This act shall take effect April 1, 2021.

PART Z

Section 1. The opening paragraph of subdivision (g) of section 31.16 of the mental hygiene law, as amended by chapter 351 of the laws of 1994, is amended to read as follows:

The commissioner may impose [a fine] <u>sanctions</u> upon a finding that the holder of the certificate has failed to comply with the terms of the operating certificate or with the provisions of any applicable statute, rule or regulation. [The maximum amount of such fine shall not exceed one thousand dollars per day or fifteen thousand dollars per violation.] <u>The commissioner is authorized to develop a schedule for the purpose of imposing such sanctions.</u>

§ 2. Subdivision (a) of section 31.04 of the mental hygiene law is amended by adding a new paragraph 8 to read as follows:

8. establishing a schedule of fees for the purpose of processing applications for the issuance of operating certificates. All fees pursuant to this section shall be payable to the office for deposit into the general fund.

§ 3. This act shall take effect on the one hundred eightieth day after it shall have become a law. Effective immediately, the commissioner of mental health is authorized to promulgate any and all rules and regulations and take any other measures necessary to implement this act on its effective date or before such date.

PART AA

Section 1. This Part enacts into law legislation relating to crisis stabilization services, Kendra's law and assisted outpatient treatment and involuntary commitment. Each component is wholly contained within a Subpart identified as Subparts A through C. The effective date for each particular provision contained within each Subpart is set forth in the last section of such Subpart. Any provision in any section contained within a Subpart, including the effective date of the Subpart, 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 Subpart in which it is found. Section three of this Part sets forth the general effective date of this Part.

SUBPART A

Section 1. The mental hygiene law is amended by adding a new section 31.36 to read as follows:

§ 31.36 Crisis stabilization services.

The commissioner shall have the power, in conjunction with the commissioner of the office of addiction services and supports, to create crisis stabilization centers within New York state in accordance with article thirty-six of this title, including the promulgation of joint regulations and implementation of a financing mechanism to allow for the sustainable operation of such programs.

§ 2. The mental hygiene law is amended by adding a new section 32.36 to read as follows:

§ 32.36 Crisis stabilization services.

The commissioner shall have the power, in conjunction with the commissioner of the office of mental health, to create crisis stabilization centers within New York state in accordance with article thirty-six of this title, including the promulgation of joint regulations and implementation of a financing mechanism to allow for the sustainable operation of such programs.

§ 3. The mental hygiene law is amended by adding a new article 36 to read as follows:

ARTICLE XXXVI

ADDICTION AND MENTAL HEALTH SERVICES AND SUPPORTS

Section 36.01 Crisis stabilization centers.

§ 36.01 Crisis stabilization centers.

(a) (1) The commissioners are authorized to jointly license crisis stabilization centers subject to the availability of state and federal funding.

(2) A crisis stabilization center shall serve as an emergency service provider for persons with psychiatric and/or substance use disorder that are in need of crisis stabilization services. Each crisis stabilization center shall provide or contract to provide crisis stabilization services for mental health or substance use twenty-four hours per day, seven days per week, including but not limited to:

(i) Engagement, triage and assessment;

(ii) Continuous observation;

(iii) Mild to moderate detoxification;

(iv) Sobering services;

(v) Therapeutic interventions;

(vi) Discharge and after care planning;

(vii) Telemedicine;

(viii) Peer support services; and

(ix) Medication assisted treatment.

(3) The commissioners shall require each crisis stabilization center to submit a plan. The plan shall be approved by the commissioners prior to the issuance of an operating certificate pursuant to this article. Each plan shall include:

(i) a description of the center's catchment area,

(ii) a description of the center's crisis stabilization services,

(iii) agreements or affiliations with hospitals as defined in section 1.03 of this chapter,

(iv) agreements or affiliations with general hospitals or law enforcement to receive persons,

(v) a description of local resources available to the center to prevent unnecessary hospitalizations of persons,

(vi) a description of the center's linkages with local police agencies, emergency medical services, ambulance services and other transportation agencies,

(vii) a description of local resources available to the center to provide appropriate community mental health and substance use disorder services upon release,

(viii) written criteria and guidelines for the development of appropriate planning for persons in need of post community treatment or services,

(ix) a statement indicating that the center has been included in an approved local services plan developed pursuant to article forty-one of this chapter for each local government located within the center's catchment area; and

(x) any other information or agreements required by the commissioners.

(4) Crisis stabilization centers shall participate in county and community planning activities annually, and as additionally needed, in order to participate in local community service planning processes to ensure, maintain, improve or develop community services that demonstrate recovery outcomes. These outcomes include, but are not limited to, quality of life, socio-economic status, entitlement status, social networking, coping skills and reduction in use of crisis services.

(b) Each crisis stabilization center shall be staffed with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community but shall have at least one psychiatrist or psychiatric nurse practitioner, a credentialed alcoholism and substance abuse counselor and one peer support specialist on duty and available at all times, provided, however, the commissioners may promulgate regulations to permit the issuance of a waiver of this

requirement when the volume of service of a center does not require such level of staff coverage.

(c) The commissioners shall promulgate regulations necessary to the operation of such crisis stabilization centers.

(d) For the purpose of addressing unique rural service delivery needs and conditions, the commissioners shall provide technical assistance for the establishment of crisis stabilization centers otherwise approved under the provisions of this section, including technical assistance to promote and facilitate the establishment of such centers in rural areas in the state or combinations of rural counties.

(e) The commissioners shall develop guidelines for educational materials to assist crisis stabilization centers in educating local practitioners, hospitals, law enforcement and peers. Such materials shall include appropriate education relating to de-escalation techniques, cultural competency, the recovery process, mental health, substance use, and avoidance of aggressive confrontation.

§ 4. Section 9.41 of the mental hygiene law, as amended by chapter 723 of the laws of 1989, is amended to read as follows:

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

Any peace officer, when acting pursuant to his or her special duties, or police officer who is a member of the state police or of an authorized police department or force or of a sheriff's department may take into custody any person who appears to be mentally ill and is conducting himself or herself in a manner which is likely to result in serious harm to the person or others. Such officer may direct the removal of such person or remove him or her to: (a) any hospital specified in subdivi-

sion (a) of section 9.39 of this article, or (b) any comprehensive psychiatric emergency program specified in subdivision (a) of section 9.40 of this article, or[,] (c) to any crisis stabilization center specified in section 36.01 of this chapter, when the officer deems such center is appropriate and where such person agrees, or (d) pending his or her examination or admission to any such hospital [or], program, or center, temporarily detain any such person in another safe and comfortable place, in which event, such officer shall immediately notify the director of community services or, if there be none, the health officer of the city or county of such action.

§ 5. Section 9.43 of the mental hygiene law, as amended by chapter 723 of the laws of 1989, is amended to read as follows:

§ 9.43 Emergency [admissions] assessment for immediate observation, care, and treatment; powers of courts.

(a) Whenever any court of inferior or general jurisdiction is informed by verified statement that a person is apparently mentally ill and is conducting himself or herself in a manner which in a person who is not mentally ill would be deemed disorderly conduct or which is likely to result in serious harm to himself or herself, such court shall issue a warrant directing that such person be brought before it. If, when said person is brought before the court, it appears to the court, on the basis of evidence presented to it, that such person has or may have a mental illness which is likely to result in serious harm to himself or herself or others, the court shall issue a civil order directing his or her removal to any hospital specified in subdivision (a) of section 9.39 of this article or any comprehensive psychiatric emergency program specified in subdivision (a) of section 9.40 of this article, or to any crisis stabilization center specified in section 36.01 of this chapter

when the court deems such center is appropriate and where such person agrees; that is willing to receive such person for a determination by the director of such hospital [or], program or center whether such person should be [retained] received therein pursuant to such section.

(b) Whenever a person before a court in a criminal action appears to have a mental illness which is likely to result in serious harm to himself or herself or others and the court determines either that the crime has not been committed or that there is not sufficient cause to believe that such person is guilty thereof, the court may issue a civil order as above provided, and in such cases the criminal action shall terminate.

§ 6. Section 9.45 of the mental hygiene law, as amended by chapter 723 of the laws of 1989 and the opening paragraph as amended by chapter 192 of the laws of 2005, is amended to read as follows:

§ 9.45 Emergency [admissions] assessment for immediate observation, care, and treatment; powers of directors of community services.

The director of community services or the director's designee shall have the power to direct the removal of any person, within his or her jurisdiction, to a hospital approved by the commissioner pursuant to subdivision (a) of section 9.39 of this article, or to a comprehensive psychiatric emergency program pursuant to subdivision (a) of section 9.40 of this article, or to any crisis stabilization center specified in section 36.01 of this chapter when the director deems such center is appropriate and where such person agrees, if the parent, adult sibling, spouse or child of the person, the committee or legal guardian of the person, a licensed psychologist, registered professional nurse or certified social worker currently responsible for providing treatment

services to the person, a supportive or intensive case manager currently assigned to the person by a case management program which program is approved by the office of mental health for the purpose of reporting under this section, a licensed physician, health officer, peace officer or police officer reports to him or her that such person has a mental illness for which immediate care and treatment [in a hospital] is appropriate and which is likely to result in serious harm to himself or herself or others. It shall be the duty of peace officers, when acting pursuant to their special duties, or police officers, who are members of an authorized police department or force or of a sheriff's department to assist representatives of such director to take into custody and transport any such person. Upon the request of a director of community services or the director's designee an ambulance service, as defined in subdivision two of section three thousand one of the public health law, is authorized to transport any such person. Such person may then be retained in a hospital pursuant to the provisions of section 9.39 of this article or in a comprehensive psychiatric emergency program pursuant to the provisions of section 9.40 of this article or to any crisis stabilization center specified in section 36.01 of this chapter when the director deems such center is appropriate and where such person agrees.

§ 7. Subdivision (a) of section 9.58 of the mental hygiene law, as added by chapter 678 of the laws of 1994, is amended to read as follows:

(a) A physician or qualified mental health professional who is a member of an approved mobile crisis outreach team shall have the power to remove, or pursuant to subdivision (b) of this section, to direct the removal of any person who appears to be mentally ill and is conducting themselves in a manner which is likely to result in serious harm to themselves or others, to a hospital approved by the commissioner pursu-

ant to subdivision (a) of section 9.39 or section 31.27 of this chapter [for the purpose of evaluation for admission if such person appears to be mentally ill and is conducting himself or herself in a manner which is likely to result in serious harm to the person or others] or where the director deems appropriate and where the person agrees, to a crisis stabilization center specified in section 36.01 of this chapter.

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

(gg) addiction and mental health services and supports provided by facilities licensed pursuant to article thirty-six of the mental hygiene law.

§ 9. Paragraph 5 of subdivision (a) of section 22.09 of the mental hygiene law, as amended by section 1 of part D of chapter 69 of the laws of 2016, is amended to read as follows:

5. "Treatment facility" means a facility designated by the commissioner which may only include a general hospital as defined in article twenty-eight of the public health law, or a medically managed or medically supervised withdrawal, inpatient rehabilitation, or residential stabilization treatment program that has been certified by the commissioner to have appropriate medical staff available on-site at all times to provide emergency services and continued evaluation of capacity of individuals retained under this section or a crisis stabilization center licensed pursuant to article 36.01 of this chapter.

§ 10. The commissioner of health, in consultation with the office of mental health and the office of addiction services and supports, shall seek Medicaid federal financial participation from the federal centers for Medicare and Medicaid services for the federal share of payments for the services authorized pursuant to this Subpart.

§ 11. This act shall take effect October 1, 2021; provided, however, that the amendments to sections 9.41, 9.43 and 9.45 of the mental hygiene law made by sections four, five and six of this act shall not affect the expiration of such sections and shall expire therewith. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date.

SUBPART B

Section 1. Paragraph 4 of subdivision (c), paragraph 2 of subdivision (h), paragraph 1 of subdivision (k) and subdivision (l) of section 9.60 of the mental hygiene law, as amended by chapter 158 of the laws of 2005 and paragraph 1 of subdivision (k) as added by chapter 1 of the laws of 2013, are amended to read as follows:

(4) has a history of lack of compliance with treatment for mental illness that has:

(i) <u>except as otherwise provided in subparagraph (ii) of this paragraph,</u> prior to the filing of the petition, at least twice within the last thirty-six months been a significant factor in necessitating hospitalization in a hospital, or receipt of services in a forensic or other mental health unit of a correctional facility or a local correctional facility, not including any current period, or period ending within the last six months, during which the person was or is hospitalized or incarcerated; or

(ii) <u>except as otherwise provided in subparagraph (iii) of this paragraph,</u> prior to the filing of the petition, resulted in one or more acts

of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last forty-eight months, not including any current period, or period ending within the last six months, in which the person was or is hospitalized or incarcerated; [and] or

(iii) notwithstanding subparagraphs (i) and (ii) of this paragraph, resulted in the issuance of an order for assisted outpatient treatment which has expired within the last six months, and since the expiration of the order, the person has experienced a substantial increase in symptoms of mental illness and a loss of function.

(2) The court shall not order assisted outpatient treatment unless an examining physician, who recommends assisted outpatient treatment and has personally examined the subject of the petition no more than ten days before the filing of the petition, testifies [in person] at the hearing. Such physician shall state the facts and clinical determinations which support the allegation that the subject of the petition meets each of the criteria for assisted outpatient treatment.

(1) Prior to the expiration of an order pursuant to this section, the appropriate director shall review whether the assisted outpatient continues to [meet the criteria for] benefit from assisted outpatient treatment. If, as documented in the petition, (i) the director determines that [such criteria continue to be met]: (A) as a result of his or her mental illness, the outpatient is unlikely to voluntarily participate in outpatient treatment that would enable him or her to live safely in the community; and (B) in view of his or her treatment history and current behavior, is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the person or others as defined in section 9.01 of this

article; and (C) the outpatient is likely to benefit from continued assisted outpatient treatment; or (ii) the director has made appropriate attempts to, but has not been successful in eliciting, the cooperation of the subject to submit to an examination, within thirty days prior to the expiration of an order of assisted outpatient treatment, such director may petition the court to order continued assisted outpatient treatment pursuant to paragraph two of this subdivision. Upon determining whether such criteria continue to be met, such director shall notify the program coordinator in writing as to whether a petition for continued assisted outpatient treatment is warranted and whether such a petition was or will be filed.

(l) Petition for an order to stay, vacate [or], modify or extend the order. (1) In addition to any other right or remedy available by law with respect to the order for assisted outpatient treatment, the assisted outpatient, the mental hygiene legal service, or anyone acting on the assisted outpatient's behalf may petition the court on notice to the director, the original petitioner, and all others entitled to notice under subdivision (f) of this section to stay, vacate [or], modify, or extend the order. An application for an extension of a current order can be made when the appropriate director has made attempts but has not been successful in giving the subject of the petition the notice of the hearing.

(2) The appropriate director shall petition the court for approval before instituting a proposed material change in the assisted outpatient treatment plan, unless such change is authorized by the order of the court. Such petition shall be filed on notice to all parties entitled to notice under subdivision (f) of this section. Not later than five days after receiving such petition, excluding Saturdays, Sundays and holi-

days, the court shall hold a hearing on the petition; provided that if the assisted outpatient informs the court that he or she agrees to the proposed material change, the court may approve such change without a hearing. Non-material changes may be instituted by the director without court approval. For the purposes of this paragraph, a material change is an addition or deletion of a category of services to or from a current assisted outpatient treatment plan, or any deviation without the assisted outpatient's consent from the terms of a current order relating to the administration of psychotropic drugs.

§ 2. This act shall take effect immediately; provided, however, that the amendments to section 9.60 of the mental hygiene law made by section one of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

SUBPART C

Section 1. The third undesignated paragraph of section 9.01 of the mental hygiene law, as amended by chapter 723 of the laws of 1989, is amended to read as follows:

"likelihood to result in serious harm" or "likely to result in serious harm" means (a) a substantial risk of physical harm to the person as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself[,]; or (b) a substantial risk of physical harm to the person arising from such complete neglect of basic needs for food, clothing, shelter or personal safety as to render serious accident, illness, or death is highly probable if care by another is not taken; or (c) a substantial risk of physical harm to other persons as manifested by

homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

§ 2. Paragraph 2 of subdivision (a) of section 9.39 of the mental hygiene law, as amended by chapter 789 of the laws of 1985, is amended and a new paragraph 3 is added to read as follows:

2. a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm[.]<u>, or</u>

<u>3. a substantial risk of physical harm to the person arising from such complete neglect of basic needs for food, clothing, shelter or personal safety as to render serious accident, illness, or death is highly probable if care by another is not taken.</u>

§ 3. This act shall take effect October 1, 2021.

§ 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 Subparts A through C of this act shall be as specifically set forth in the last section of such Subparts.

PART BB

Section 1. Subdivision (b) of section 7.17 of the mental hygiene law, as amended by section 1 of part H of chapter 56 of the laws of 2013, is amended to read as follows:

(b) There shall be in the office the hospitals named below for the care, treatment and rehabilitation of persons with mental illness and for research and teaching in the science and skills required for the care, treatment and rehabilitation of such persons with mental illness.

Greater Binghamton Health Center
Bronx Psychiatric Center
Buffalo Psychiatric Center
Capital District Psychiatric Center
Central New York Psychiatric Center
Creedmoor Psychiatric Center
Elmira Psychiatric Center
Kingsboro Psychiatric Center
Kirby Forensic Psychiatric Center
Manhattan Psychiatric Center
Mid-Hudson Forensic Psychiatric Center
Mohawk Valley Psychiatric Center
Nathan S. Kline Institute for Psychiatric Research
New York State Psychiatric Institute
Pilgrim Psychiatric Center
Richard H. Hutchings Psychiatric Center
Rochester Psychiatric Center
Rockland Psychiatric Center
St. Lawrence Psychiatric Center
South Beach Psychiatric Center
New York City Children's Center

Rockland Children's Psychiatric Center

Sagamore Children's Psychiatric Center

Western New York Children's Psychiatric Center

The New York State Psychiatric Institute and The Nathan S. Kline Institute for Psychiatric Research are designated as institutes for the conduct of medical research and other scientific investigation directed towards furthering knowledge of the etiology, diagnosis, treatment and prevention of mental illness. The New York State Psychiatric Institute shall operate, as a sub-entity, the New York State Institute for Basic Research in Developmental Disabilities, which is designated as an institute for the conduct of medical research and other scientific investigation directed towards furthering knowledge of the etiology, diagnosis, treatment and prevention of developmental disabilities.

§ 2. All employees of the office for people with developmental disabilities' New York State Institute for Basic Research in Developmental Disabilities, who are substantially engaged in the functions to be transferred, will be transferred to the office of mental health's New York State Psychiatric Institute pursuant to subdivision 2 of section 70 of the civil service law.

§ 3. This act shall take effect immediately

PART CC

Section 1. Subdivisions 2 and 2-a of section 1.03 of the mental hygiene law, subdivision 2 as amended and subdivision 2-a as added by chapter 281 of the laws of 2019, are amended to read as follows:

2. ["Commissioner" means the commissioner of mental health] "Commissioner" means the commissioner of addiction and mental health services,

and the commissioner of developmental disabilities [and the commissioner of addiction services and supports] as used in this chapter. Any power or duty heretofore assigned to the commissioner of mental hygiene or to the department of mental hygiene pursuant to this chapter shall hereafter be assigned to the commissioner of addiction and mental health services in the case of facilities, programs, or services for individuals with mental illness, to the commissioner of developmental disabilities in the case of facilities, programs, or services for individuals with developmental disabilities, to the commissioner of addiction and mental health services [and supports] in the case of facilities, programs, or addiction disorder services in accordance with the provisions of titles D and E of this chapter.

2-a. Notwithstanding any other section of law or regulation, on and after the effective date of this subdivision, any and all references to the office of alcoholism and substance abuse services and the predecessor agencies to the office of alcoholism and substance abuse services including the division of alcoholism and alcohol abuse and the division of substance abuse services and all references to the office of mental health, shall be known as the "office of addiction and mental health services [and supports]." Nothing in this subdivision shall be construed as requiring or prohibiting the further amendment of statutes or regulations to conform to the provisions of this subdivision.

§ 2. Section 5.01 of the mental hygiene law, as amended by chapter 281 of the laws of 2019, is amended and two new sections 5.01-a and 5.01-b are added to read as follows:

§ 5.01 Department of mental hygiene.

There shall continue to be in the state government a department of mental hygiene. Within the department there shall be the following autonomous offices:

(1) office of addiction and mental health services; and

(2) office for people with developmental disabilities[;

(3) office of addiction services and supports].

§ 5.01-a Office of addiction and mental health services.

(a) The office of addiction and mental health services shall be a new office within the department formed by the integration of the offices of mental health and addiction services and supports which shall focus on issues related to both mental illness and addiction in the state and carry out the intent of the legislature in establishing the offices pursuant to articles seven and nineteen of this chapter. The office of addiction and mental health services is charged with ensuring the development of comprehensive plans for programs and services in the area of research, prevention, and care and treatment, rehabilitation, education and training, and shall be staffed to perform the responsibilities attributed to the office pursuant to sections 7.07 and 19.07 of this chapter and provide services and programs to promote recovery for individuals with mental illness, substance use disorder, or mental illness and substance use disorder.

(b) The commissioner of the office of addiction and mental health services shall be vested with the powers, duties, and obligations of the office of mental health and the office of addiction services and supports.

(c) The office of addiction and mental health services may license providers to provide integrated services for individuals with mental

illness, substance use disorder, or mental illness and substance use disorder, in accordance with regulations issued by the commissioner.

§ 5.01-b Office of addiction and mental health services.

Until January first, two thousand twenty-two, the office of addiction and mental health services shall consist of the office of mental health and the office of addiction services and supports.

§ 3. Section 5.03 of the mental hygiene law, as amended by chapter 281 of the laws of 2019, is amended to read as follows:

§ 5.03 Commissioners.

The head of the office of addiction and mental health services shall be the commissioner of addiction and mental health services; and the head of the office for people with developmental disabilities shall be the commissioner of developmental disabilities[; and the head of the office of addiction services and supports shall be the commissioner of addiction services and supports]. Each commissioner shall be appointed by the governor, by and with the advice and consent of the senate, to serve at the pleasure of the governor. Until the commissioner of addiction and mental health services is appointed by the governor and confirmed by the senate, the commissioner of mental health and the commissioner of addiction services and supports shall continue to oversee mental health and addiction services respectively, and work collaboratively to integrate care for individuals with both mental health and substance use disorders.

§ 4. Section 5.05 of the mental hygiene law, as added by chapter 978 of the laws of 1977, subdivision (a) as amended by chapter 168 of the laws of 2010, subdivision (b) as amended by chapter 294 of the laws of 2007, paragraph 1 of subdivision (b) as amended by section 14 of part J of chapter 56 of the laws of 2012, subdivision (d) as added by chapter

58 of the laws of 1988 and subdivision (e) as added by chapter 588 of the laws of 2011, is amended to read as follows:

§ 5.05 Powers and duties of the head of the department.

(a) The commissioners of the office of addiction and mental health services and the office for people with developmental disabilities, as the heads of the department, shall jointly visit and inspect, or cause to be visited and inspected, all facilities either public or private used for the care, treatment and rehabilitation of individuals with mental illness, substance use disorder and developmental disabilities in accordance with the requirements of section four of article seventeen of the New York state constitution.

(b) (1) The commissioners of the office of addiction and mental health[,] services and the office for people with developmental disabilities [and the office of alcoholism and substance abuse services] shall constitute an inter-office coordinating council which, consistent with the autonomy of each office for matters within its jurisdiction, shall ensure that the state policy for the prevention, care, treatment and rehabilitation of individuals with mental illness, substance use disorders and developmental disabilities[, alcoholism, alcohol abuse, substance abuse, substance dependence, and chemical dependence] is planned, developed and implemented comprehensively; that gaps in services to individuals with multiple disabilities are eliminated and that no person is denied treatment and services because he or she has more than one disability; that procedures for the regulation of programs which offer care and treatment for more than one class of persons with mental disabilities be coordinated between the offices having jurisdiction over such programs; and that research projects of the institutes, as identified in section 7.17 [or], 13.17, or 19.17 of this chapter or

as operated by the office for people with developmental disabilities, are coordinated to maximize the success and cost effectiveness of such projects and to eliminate wasteful duplication.

(2) The inter-office coordinating council shall annually issue a report on its activities to the legislature on or before December thirty-first. Such annual report shall include, but not be limited to, the following information: proper treatment models and programs for persons with multiple disabilities and suggested improvements to such models and programs; research projects of the institutes and their coordination with each other; collaborations and joint initiatives undertaken by the offices of the department; consolidation of regulations of each of the offices of the department to reduce regulatory inconsistencies between the offices; inter-office or office activities related to workforce training and development; data on the prevalence, availability of resources and service utilization by persons with multiple disabilities; eligibility standards of each office of the department affecting clients suffering from multiple disabilities, and eligibility standards under which a client is determined to be an office's primary responsibility; agreements or arrangements on statewide, regional and local government levels addressing how determinations over client responsibility are made and client responsibility disputes are resolved; information on any specific cohort of clients with multiple disabilities for which substantial barriers in accessing or receiving appropriate care has been reported or is known to the inter-office coordinating council or the offices of the department; and coordination of planning, standards or services for persons with multiple disabilities between the inter-office coordinating council, the offices of the department and local govern-

ments in accordance with the local planning requirements set forth in article forty-one of this chapter.

(c) The commissioners shall meet from time to time with the New York state conference of local mental hygiene directors to assure consistent procedures in fulfilling the responsibilities required by this section and by article forty-one of this chapter.

(d) 1. The commissioner of addiction and mental health services shall evaluate the type and level of care required by patients in the adult psychiatric centers authorized by section 7.17 of this chapter and develop appropriate comprehensive requirements for the staffing of inpatient wards. These requirements should reflect measurable need for administrative and direct care staff including physicians, nurses and other clinical staff, direct and related support and other support staff, established on the basis of sound clinical judgment. The staffing requirements shall include but not be limited to the following: (i) the level of care based on patient needs, including on ward activities, (ii) the number of admissions, (iii) the geographic location of each facility, (iv) the physical layout of the campus, and (v) the physical design of patient care wards.

2. Such commissioner, in developing the requirements, shall provide for adequate ward coverage on all shifts taking into account the number of individuals expected to be off the ward due to sick leave, workers' compensation, mandated training and all other off ward leaves.

3. The staffing requirements shall be designed to reflect the legitimate needs of facilities so as to ensure full accreditation and certification by appropriate regulatory bodies. The requirements shall reflect appropriate industry standards. The staffing requirements shall be fully measurable.

[4. The commissioner of mental health shall submit an interim report to the governor and the legislature on the development of the staffing requirements on October first, nineteen hundred eighty-eight and again on April first, nineteen hundred eighty-nine. The commissioner shall submit a final report to the governor and the legislature no later than October first, nineteen hundred eighty-nine and shall include in his report a plan to achieve the staffing requirements and the length of time necessary to meet these requirements.]

(e) The commissioners of the office of addiction and mental health[,] services and the office for people with developmental disabilities[, and the office of alcoholism and substance abuse services] shall cause to have all new contracts with agencies and providers licensed by the offices to have a clause requiring notice be provided to all current and new employees of such agencies and providers stating that all instances of abuse shall be investigated pursuant to this chapter, and, if an employee leaves employment prior to the conclusion of a pending abuse investigation, the investigation shall continue. Nothing in this section shall be deemed to diminish the rights, privileges, or remedies of any employee under any other law or regulation or under any collective bargaining agreement or employment contract.

§ 5. Section 7.01 of the mental hygiene law, as added by chapter 978 of the laws of 1977, is amended to read as follows:

§ 7.01 Declaration of policy.

The state of New York and its local governments have a responsibility for the prevention and early detection of mental illness and for the comprehensively planned care, treatment and rehabilitation of their mentally ill citizens.

Therefore, it shall be the policy of the state to conduct research and to develop programs which further prevention and early detection of mental illness; to develop a comprehensive, integrated system of treatment and rehabilitative services for the mentally ill. Such a system should include, whenever possible, the provision of necessary treatment services to people in their home communities; it should assure the adequacy and appropriateness of residential arrangements for people in need of service; and it should rely upon improved programs of institutional care only when necessary and appropriate. Further, such a system should recognize the important therapeutic roles of all disciplines which may contribute to the care or treatment of the mentally ill, such as psychology, social work, psychiatric nursing, special education and other disciplines in the field of mental illness, as well as psychiatry and should establish accountability for implementation of the policies of the state with regard to the care and rehabilitation of the mentally ill.

To facilitate the implementation of these policies and to further advance the interests of the mentally ill and their families, a new autonomous agency to be known as the office of <u>addiction and</u> mental health <u>services</u> has been established by this article. The office and its commissioner shall plan and work with local governments, voluntary agencies and all providers and consumers of mental health services in order to develop an effective, integrated, comprehensive system for the delivery of all services to the mentally ill and to create financing procedures and mechanisms to support such a system of services to ensure that mentally ill persons in need of services receive appropriate care, treatment and rehabilitation close to their families and communities. In carrying out these responsibilities, the office and its commissioner

shall make full use of existing services in the community including those provided by voluntary organizations.

§ 6. Section 19.01 of the mental hygiene law, as added by chapter 223 of the laws of 1992, is amended to read as follows:

§ 19.01 Declaration of policy.

The legislature declares the following:

Alcoholism, substance abuse and chemical dependence pose major health and social problems for individuals and their families when left untreated, including family devastation, homelessness, and unemployment. It has been proven that successful prevention and treatment can dramatically reduce costs to the health care, criminal justice and social welfare systems.

The tragic, cumulative and often fatal consequences of alcoholism and substance abuse are, however, preventable and treatable disabilities that require a coordinated and multi-faceted network of services.

The legislature recognizes locally planned and implemented prevention as a primary means to avert the onset of alcoholism and substance abuse. It is the policy of the state to promote comprehensive, age appropriate education for children and youth and stimulate public awareness of the risks associated with alcoholism and substance abuse. Further, the legislature acknowledges the need for a coordinated state policy for the establishment of prevention and treatment programs designed to address the problems of chemical dependency among youth, including prevention and intervention efforts in school and community-based programs designed to identify and refer high risk youth in need of chemical dependency services.

Substantial benefits can be gained through alcoholism and substance abuse treatment for both addicted individuals and their families. Posi-

tive treatment outcomes that may be generated through a complete continuum of care offer a cost effective and comprehensive approach to rehabilitating such individuals. The primary goals of the rehabilitation and recovery process are to restore social, family, lifestyle, vocational and economic supports by stabilizing an individual's physical and psychological functioning. The legislature recognizes the importance of varying treatment approaches and levels of care designed to meet each client's needs. Relapse prevention and aftercare are two primary components of treatment that serve to promote and maintain recovery.

The legislature recognizes that the distinct treatment needs of special populations, including women and women with children, persons with HIV infection, persons diagnosed with mental illness, persons who abuse chemicals, the homeless and veterans with posttraumatic stress disorder, merit particular attention. It is the intent of the legislature to promote effective interventions for such populations in need of particular attention. The legislature also recognizes the importance of family support for individuals in alcohol or substance abuse treatment and recovery. Such family participation can provide lasting support to the recovering individual to prevent relapse and maintain recovery. The intergenerational cycle of chemical dependency within families can be intercepted through appropriate interventions.

The state of New York and its local governments have a responsibility in coordinating the delivery of alcoholism and substance abuse services, through the entire network of service providers. To accomplish these objectives, the legislature declares that the establishment of a single, unified office of [alcoholism and substance abuse] <u>addiction and mental health</u> services will provide an integrated framework to plan, oversee and regulate the state's prevention and treatment network. In recogni-

tion of the growing trends and incidence of chemical dependency, this consolidation allows the state to respond to the changing profile of chemical dependency. The legislature recognizes that some distinctions exist between the alcoholism and substance abuse field and the mental health field and where appropriate, those distinctions may be preserved. Accordingly, it is the intent of the state to establish one office of [alcoholism and substance abuse] addiction and mental health services in furtherance of a comprehensive service delivery system.

§ 7. Upon or prior to January 1, 2022, the governor may nominate an individual to serve as commissioner of the office of addiction and mental health services. If such individual is confirmed by the senate prior to January 1, 2022, they shall become the commissioner of the office of addiction and mental health services. The governor may designate a person to exercise the powers of the commissioner of the office of addiction and mental health services on an acting basis, until confirmation of a nominee by the senate, who is hereby authorized to take such actions as are necessary and proper to implement the orderly transition of the functions, powers as duties as herein provided, including the preparation for a budget request for the office as established by this act.

§ 8. Upon the transfer pursuant to this act of the functions and powers possessed by and all of the obligations and duties of the office of mental health and the office of addiction services and supports as established pursuant to the mental hygiene law and other laws, to the office of addiction and mental health services as prescribed by this act, provision shall be made for the transfer of all employees from the office of mental health and the office of addiction services and supports into the office of addiction and mental health services.

Employees so transferred shall be transferred without further examination or qualification to the same or similar titles and shall remain in the same collective bargaining units and shall retain their respective civil service classifications, status, and rights pursuant to their collective bargaining units and collective bargaining agreements.

§ 9. Notwithstanding any contrary provision of law, on or before October 1, 2021 and annually thereafter, the office of addiction and mental health services, in consultation with the department of health, shall issue a report, and post such report on their public website, detailing the office's expenditures for mental health and addiction services and supports, including total Medicaid spending directly by the state to licensed or designated providers and payments to managed care providers pursuant to section 364-j of the social services law. The office of addiction and mental health services shall examine reports produced pursuant to this section and may make recommendations to the governor and the legislature regarding appropriations for mental health and addiction services and supports or other provisions of law which may be necessary to effectively implement the creation and continued operation of the office.

§ 10. Severability. If any clause, sentence, paragraph, 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, section or part thereof directly involved in the controversy in which such judgment shall have been rendered.

§ 11. This act shall take effect immediately. Effective immediately, the office of mental health and the office of addiction services and supports are authorized to promulgate the addition, amendment and/or

repeal of any rule or regulation or engage in any work necessary for the implementation of this act on its effective date authorized to be made and completed on or before such effective date.

PART DD

Section 1. This act shall be known and may be cited as the "comprehensive outpatient services act of 2021".

§ 2. Section 364-m of the social services law is amended by adding a new subdivision 6 to read as follows:

6. Comprehensive outpatient services centers. (a) Definitions. For the purpose of this article, unless the context clearly requires otherwise:

(i) "Mental health services" means services for the treatment of mental illness.

(ii) "Addiction services" means services for the treatment of addiction disorders.

(iii) "Comprehensive outpatient services" means the systematic coordination of evidence-based health care services, to include the preventative, diagnostic, therapeutic and rehabilitative care and treatment of mental illness, addiction and the provision of physical health services, otherwise provided by a diagnostic and treatment center or general hospital outpatient program pursuant to article twenty-eight of the public health law, a mental health clinic licensed pursuant to article thirty-one of the mental hygiene law, or an addiction provider certified pursuant to article thirty-two of the mental hygiene law to an individual seeking services regardless of their primary diagnosis or health

complaint; provided, however, that the scope of such services may be restricted pursuant to regulation.

(iv) "Comprehensive outpatient services centers" means a facility approved in accordance with this section to provide comprehensive outpatient services in order to promote health and better outcomes for the recipient, particularly for populations at risk.

(v) "Medical director" is a physician who is responsible for the services delivered by the comprehensive outpatient services provider, for the overall direction of the services provided and the direct supervision of medical staff in the delivery of services.

(vi) "Physical health services" means services provided by a physician, physician's assistant, nurse practitioner, or midwife acting within his or her lawful scope of practice under title eight of the education law and who is practicing in a primary care specialty.

(b) Notwithstanding any law, rule, or regulation to the contrary, the commissioners of the department of health, the office of mental health, and the office of addiction services and supports are authorized to jointly establish a single set of licensing standards and requirements for the construction, operation, reporting and surveillance of comprehensive outpatient services centers. Such standards and requirements shall include, but not be limited to:

(i) scope of comprehensive outpatient services;

(ii) creation of an efficient application review process for comprehensive outpatient services centers;

(iii) facilitation of integrated treatment records that comply with applicable federal and state confidentiality requirements;

(iv) optimal use of clinical resources, including the development of a workforce capable of providing comprehensive care to an individual utilizing evidence-based approaches to integrated treatment;

(v) development of billing and reimbursement structures to enable the provision of comprehensive services to individuals regardless of their primary diagnosis or healthcare complaint;

(vi) reasonable physical plant standards to foster proper care and treatment;

(vii) standards for incident reporting and remediation pursuant to article eleven of the social services law; and

(viii) standards for adverse event reporting, provided however that any such adverse event reports shall be kept confidential and shall not be subject to disclosure under article six of the public officers law or article thirty-one of the civil practice law and rules.

(c) A provider shall not be authorized to provide comprehensive outpatient services unless they have sufficiently demonstrated, consistent with the standards and requirements set forth by the commissioners:

(i) experience in the delivery of physical, mental health, and addiction services;

(ii) capacity to offer comprehensive outpatient services in each comprehensive outpatient services center approved by each of the commissioners of the department of health, the office of mental health, and the office of addiction services and supports; and

(iii) compliance with standards established pursuant to this section for providing and receiving payment for comprehensive outpatient services.

(d) Notwithstanding any provision of law to the contrary, for the purposes of this subdivision, comprehensive outpatient service providers

shall be considered contracted, approved or otherwise authorized by the office of addiction services and supports and the office of mental health for the purpose of sections 19.20, 19.20-a, and 31.35 of the mental hygiene law, as may be applicable. Providers shall be required to comply with the review of criminal history information, as required in such sections, for prospective employees or volunteers who will have regular and substantial unsupervised or unrestricted physical contact with the clients of such provider.

(e) The commissioners of the department of health, the office of mental health, and the office of addiction services and supports are authorized to promulgate any regulatory requirements necessary to implement comprehensive outpatient services centers consistent with this section, including amending existing requirements.

§ 3. Subdivision 4 of section 488 of the social services law is amended by adding a new paragraph (a-1) to read as follows:

(a-1) a comprehensive outpatient services center which is licensed, or certified by section three hundred sixty-four-m of this chapter, provided however that such term shall not include the provision of physical health services rendered in such facility or program;

§ 4. Subdivision 1 of section 2801 of the public health law, as amended by section 1 of part Z of chapter 57 of the laws of 2019, is amended to read as follows:

1. "Hospital" means a facility or institution engaged principally in providing services by or under the supervision of a physician or, in the case of a dental clinic or dental dispensary, of a dentist, or, in the case of a midwifery birth center, of a midwife, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, including, but not limited to, a general hospital,

public health center, diagnostic center, treatment center, dental clinic, dental dispensary, rehabilitation center other than a facility used solely for vocational rehabilitation, nursing home, tuberculosis hospital, chronic disease hospital, maternity hospital, midwifery birth center, lying-in-asylum, out-patient department, out-patient lodge, dispensary and a laboratory or central service facility serving one or more such institutions, but the term hospital shall not include an institution, sanitarium or other facility engaged principally in providing services for the prevention, diagnosis or treatment of mental disability and which is subject to the powers of visitation, examination, inspection and investigation of the department of mental hygiene except for those distinct parts of such a facility which provide hospital service. The provisions of this article shall not apply to a facility or institution engaged principally in providing services by or under the supervision of the bona fide members and adherents of a recognized religious organization whose teachings include reliance on spiritual means through prayer alone for healing in the practice of the religion of such organization and where services are provided in accordance with those teachings. No provision of this article or any other provision of law shall be construed to: (a) <u>apply to comprehensive outpatient services centers, as defined in section three hundred sixty-four-m of the social services law; (b)</u> limit the volume of mental health, substance use disorder services or developmental disability services that can be provided by a provider of primary care services licensed under this article and authorized to provide integrated services in accordance with regulations issued by the commissioner in consultation with the commissioner of the office of mental health, the commissioner of the office of [alcoholism and substance abuse services] <u>addiction services and</u>

supports and the commissioner of the office for people with developmental disabilities, including regulations issued pursuant to subdivision seven of section three hundred sixty-five-l of the social services law or part L of chapter fifty-six of the laws of two thousand twelve; [(b)] (c) require a provider licensed pursuant to article thirty-one of the mental hygiene law or certified pursuant to article sixteen or article thirty-two of the mental hygiene law to obtain an operating certificate from the department if such provider has been authorized to provide integrated services in accordance with regulations issued by the commissioner in consultation with the commissioner of the office of mental health, the commissioner of the office of [alcoholism and substance abuse services] addiction services and supports and the commissioner of the office for people with developmental disabilities, including regulations issued pursuant to subdivision seven of section three hundred sixty-five-l of the social services law or part L of chapter fifty-six of the laws of two thousand twelve.

§ 5. Subdivision (f) of section 31.02 of the mental hygiene law, as amended by section 2 of part Z of chapter 57 of the laws of 2019, is amended to read as follows:

(f) No provision of this article or any other provision of law shall be construed to require a provider licensed pursuant to article twenty-eight of the public health law or certified pursuant to article sixteen or article thirty-two of this chapter to obtain an operating certificate from the office of mental health if such provider has been authorized to provide integrated services in accordance with regulations issued by the commissioner of the office of mental health in consultation with the commissioner of the department of health, the commissioner of the office of [alcoholism and substance abuse services] addiction services and

supports and the commissioner of the office for people with developmental disabilities, including regulations issued pursuant to subdivision seven of section three hundred sixty-five-l of the social services law or part L of chapter fifty-six of the laws of two thousand twelve. Furthermore, except as provided in paragraph (d) of subdivision six of section three hundred sixty-four-m of the social services law, no provision of this article or any other provision of law shall be construed to apply to comprehensive outpatient services centers, as defined in section three hundred sixty-four-m of the social services law.

§ 6. Subdivision (b) of section 32.05 of the mental hygiene law, as amended by section 3 of part Z of chapter 57 of the laws of 2019, is amended to read as follows:

(b) (i) Methadone, or such other controlled substance designated by the commissioner of health as appropriate for such use, may be administered to an addict, as defined in section thirty-three hundred two of the public health law, by individual physicians, groups of physicians and public or private medical facilities certified pursuant to article twenty-eight or thirty-three of the public health law as part of a chemical dependence program which has been issued an operating certificate by the commissioner pursuant to subdivision (b) of section 32.09 of this article, provided, however, that such administration must be done in accordance with all applicable federal and state laws and regulations. Individual physicians or groups of physicians who have obtained authorization from the federal government to administer buprenorphine to addicts may do so without obtaining an operating certificate from the commissioner. (ii) No provision of this article or any other provision of law shall be construed to require a provider licensed pursuant to

article twenty-eight of the public health law, article thirty-one of this chapter or a provider certified pursuant to article sixteen of this chapter to obtain an operating certificate from the office of [alcoholism and substance abuse services] addiction services and supports if such provider has been authorized to provide integrated services in accordance with regulations issued by the commissioner of [alcoholism and substance abuse services] addiction services and supports in consultation with the commissioner of the department of health, the commissioner of the office of mental health and the commissioner of the office for people with developmental disabilities, including regulations issued pursuant to subdivision seven of section three hundred sixty-five-l of the social services law or part L of chapter fifty-six of the laws of two thousand twelve. Furthermore, except as provided in paragraph (d) of subdivision six of section three hundred sixty-four-m of the social services law, no provision of this article or any other provision of law shall be construed to apply to comprehensive outpatient services centers, as defined in section three hundred sixty-four-m of the social services law.

§ 7. This act shall take effect January 1, 2022; provided, however, that the amendments to section 364-m of the social services law made by section two of this act shall not affect the repeal of such section and shall be deemed to repeal therewith. Effective immediately, the commissioner of the department of health, the commissioner of the office of mental health and the commissioner of the office of addiction services and supports are authorized to issue any rule or regulation necessary for the implementation of this act on or before its effective date.

PART EE

Section 1. Subdivision 10 of section 553 of the executive law is REPEALED.

§ 2. This act shall take effect April 1, 2021.

§ 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 EE of this act shall be as specifically set forth in the last section of such Parts.