STATE OF NEW YORK

S. 3007 A. 3007

SENATE - ASSEMBLY

January 22, 2025

IN SENATE -- A BUDGET BILL, submitted by the Governor pursuant to article seven of the Constitution -- read twice and ordered printed, and when printed to be committed to the Committee on Finance

IN ASSEMBLY -- A BUDGET BILL, submitted by the Governor pursuant to article seven of the Constitution -- read once and referred to the Committee on Ways and Means

AN ACT to amend part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to general hospital reimbursement for annual rates, in relation to known and projected department of health state fund medicaid expenditures (Part A); to amend part B of chapter 57 of the laws of 2015, amending the social services law and other laws relating to supplemental rebates, in relation to extending the expiration thereof; to amend chapter 942 of the laws of 1983 and chapter 541 of the laws of 1984 relating to foster family care demonstration programs, in relation to extending the expirations thereof; to amend chapter 256 of the laws of 1985, amending the social services law and other laws relating to foster family care demonstration programs, in relation to extending the expiration thereof; to amend the social services law, in relation to extending provisions relating to health and mental hygiene; to amend part C of chapter 58 of the laws of 2009, amending the public health law relating to payment by governmental agencies for general hospital inpatient services, in relation to the effectiveness thereof; to amend chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential healthcare facilities, in relation to the effectiveness thereof; to amend section 2 of chapter 137 of the laws of 2023, amending the public health law relating to establishing a community-based paramedicine demonstration program, in relation to extending the effectiveness thereof; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to extending the effectiveness of certain provisions thereof; to amend part FFF of chapter 59 of the laws of 2018, amending the public health law relating to authorizing the commissioner of health to redeploy excess reserves of certain not-for-profit managed care organizations, in relation to the effectiveness thereof; to amend chapter 451 of the

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

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laws of 2007, amending the public health law, the social services law and the insurance law relating to providing enhanced consumer and provider protections, in relation to the effectiveness of certain provisions relating to contracts between plans, insurers, or corporations and hospitals; to amend the public health law, in relation to reimbursement rate promulgation for residential health care facilities, and in relation to certified home health agency services payments; to amend part C of chapter 60 of the laws of 2014, amending the social services law relating to fair hearings within the Fully Integrated Duals Advantage program, in relation to the effectiveness thereof; to amend chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, in relation to extending the provisions thereof; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to the effectiveness of certain provisions thereof; to amend part A of chapter 56 of the laws of 2013, amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates, in relation to extending government rates for behavioral services; to amend the public health law, in relation to gross receipts for general hospital assessments; to amend part MM of chapter 57 of the laws of 2021 amending the public health law relating to aiding in the transition to adulthood for children with medical fragility living in pediatric nursing homes and other settings, in relation to the effectiveness thereof; to amend chapter 633 of the laws of 2006, amending the public health law relating to the home based primary care for the elderly demonstration project, in relation to the effectiveness thereof; to amend chapter 19 of the laws of 1998, amending the social services law relating to limiting the method of payment for prescription drugs under the medical assistance program, in relation to the effectiveness thereof; to amend part BBB of chapter 56 of the laws of 2022, amending the public health law and other laws relating to permitting the commissioner of health to submit a waiver that expands eligibility for New York's basic health program and increases the federal poverty limit cap for basic health program eligibility from two hundred to two hundred fifty percent, in relation to extending certain provisions related to providing long-term services and supports under the essential plan; to amend the social services law, in relation to which contracts stay in force after September 30, 2025; and to amend part MM of chapter 56 of the laws of 2020 directing the department of health to establish or procure the services of an independent panel of clinical professionals and to develop and implement a uniform task-based assessment tool, in relation to which contracts stay in force after September 30, 2025 (Part B); to amend the public health law, in relation to prescriber prevails; and to repeal certain provisions of the social services law relating to coverage for certain prescription drugs (Part C); to amend the public health law, in relation to reducing the hospital capital rate add-on (Part D); to amend the financial services law, in relation to excluding managed care plans from the independent resolution process; and to amend the social services law, in relation to shifting long-term nursing home stays from managed care to fee for service, and authorizing penalties for managed care plans that do not meet contractual obligations (Part E); to amend the public health law, in relation to establishing a tax on managed care providers; to amend the state

finance law, in relation to the healthcare stability fund; and to amend part I of chapter 57 of the laws of 2022 providing a one percent across the board payment increase to all qualifying fee-for-service Medicaid rates, in relation to certain Medicaid payments made for certain medical services (Part F); to amend chapter 266 of the laws of 1986 amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to insurance coverage paid for by funds from the hospital excess liability pool and extending the effectiveness of certain provisions thereof; to amend part J of chapter 63 of the laws of 2001 amending chapter 266 of the laws of 1986 amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to extending certain provisions concerning the hospital excess liability pool; and to amend part H of chapter 57 of the laws of 2017 amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions relating thereto, in relation to extending provisions relating to excess coverage (Part G); to repeal section 461-s of the social services law relating to enhancing the quality of adult living; to repeal paragraph (c) of subdivision 1 of section 461-b of the social services law, relating to enriched housing programs; to amend the public health law and the state finance law, in relation to the discontinuation of the empire clinical research investigator program; and to repeal article 27-H of the public health law relating to the tick-borne disease institute (Part H); to amend the public health law, in relation to eliminating the fees paid by funeral directors for permits for burials and removals which are used to support the electronic death registration system; and to repeal certain provisions of such law relating thereto (Part I); to amend the public health law, in relation to the due date for awards applied for under the statewide health care facility transformation III program (Part J); to amend the public health law, in relation to appointing a temporary operator for general hospitals, diagnostic and treatment centers, and adult care facilities (Part K); to amend the public health law, in relation to removing the requirement that consent for the payment of certain medical services must occur after such services are administered (Part L); to amend the public health law, in relation to requiring general hospitals to report community benefit spending (Part M); to amend the public health law, in relation to expanding the purposes of the spinal cord injury research board (Part N); to amend the public health law, in relation to updating controlled substance schedules to conform with those of the federal drug enforcement administration and updating the term "addict" to "person with a substance use disorder" (Part O); to amend the public health law, in relation to emergency medical treatment protocols for maternity patients; and to amend the education law, in relation to labeling of abortion medications (Part P); to amend the social services law and the public health law, in relation to establishing increased coverage of care as well as availability of care for infertility treatments; and to repeal section 4 of part K of chapter 82 of the laws of 2002 amending the insurance law and the public health law relating to coverage for the diagnosis and treatment of infertility, relating to the establishment of a program to provide grants to health care providers for improving access to infertility services (Part Q); to amend the public health law and the general municipal law, in relation to requiring the development of a statewide comprehensive emergency medical system plan and county EMS plans, and

declaring EMS an essential service (Part R); to amend the public health law, in relation to strengthening material transactions reporting requirements (Part S); to amend the public health law, in relation to requiring hospitals to maintain sexual assault forensic examiners at their facilities (Part T); to amend the public health law, in relation to eliminating administrative barriers to, and offset actual costs of, timely fulfillment of vital records requests; and to repeal certain provisions of such law relating thereto (Part U); to amend the education law and the public health law, in relation to the scope of practice of certified nurse aides; and providing for the repeal of such provisions upon the expiration thereof (Subpart A); to amend the education law and the public health law, in relation to the scope and practice of medical assistants (Subpart B); to amend the education law, in relation to the administration of certain immunizations by pharmacists and pharmacy technicians (Subpart C); to amend the education law, in relation to authorizing a licensed pharmacist to prescribe and order medications to treat nicotine dependence for smoking cessation (Subpart D); to repeal certain articles of the education law governing certain healthcare professions and adding such laws to the public health law and transferring all functions, powers, duties, obligations and appropriations relating thereto (Subpart E); and to amend the education law and the public health law, in relation to physician assistants (Subpart F) (Part V); to amend the education law, in relation to enacting the nurse licensure compact (Part W); to amend the education law, in relation to the scope of practice of dental hygienists (Part X); to amend the public health law, in relation to extending hospital services outside the facility and into patients' residences (Part Y); to amend chapter 565 of the laws of 2022 amending the state finance law relating to preferred source status for entities that provide employment to certain persons, in relation to the effectiveness thereof (Part Z); to amend part NN of chapter 58 of the laws of 2015, amending the mental hygiene law relating to clarifying the authority of the commissioners in the department of mental hygiene to design and implement time-limited demonstration programs, in relation to the effectiveness thereof (Part AA); to amend part L of chapter 59 of the laws of 2016, amending the mental hygiene law relating to the appointment of temporary operators for the continued operation of programs and the provision of services for persons with serious mental illness and/or developmental disabilities and/or chemical dependence, in relation to the effectiveness thereof (Part BB); to amend part A of chapter 56 of the laws of 2013, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2013-2014 state fiscal year, in relation to the effectiveness of certain provisions thereof (Part CC); to amend the mental hygiene law and the public health law, in relation to adding homeless youth to the definition of minors for the purpose of consent for certain treatment (Part DD); to amend the mental hygiene law, in relation to involuntary admission and assisted outpatient treatment (Part EE); and in relation to establishing a targeted inflationary increase for designated programs (Part FF)

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

Section 1. This act enacts into law major components of legislation necessary to implement the state health and mental hygiene budget for the 2025-2026 state fiscal year. Each component is wholly contained within a Part identified as Parts A through FF. The effective date for each particular provision contained within such Part is set forth in the last section of such Part. Any provision in any section contained within a Part, including the effective date of the Part, which makes a reference to a section "of this act", when used in connection with that particular component, shall be deemed to mean and refer to the corresponding section of the Part in which it is found. Section three of this act sets forth the general effective date of this act.

PART A

Section 1. Paragraph (a) of subdivision 1 of section 92 of part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to general hospital reimbursement for annual rates, as amended by section 1 of part A of chapter 57 of the laws of 2024, is amended to read as follows:

(a) For state fiscal years 2011-12 through [2025-26] 2026-27, the director of the budget, in consultation with the commissioner of health referenced as "commissioner" for purposes of this section, shall assess on a quarterly basis, as reflected in quarterly reports pursuant to subdivision five of this section known and projected department of health state funds medicaid expenditures by category of service and by geographic regions, as defined by the commissioner.

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

PART B

Section 1. Subdivision 1-a of section 60 of part B of chapter 57 of the laws of 2015, amending the social services law and other laws relating to supplemental rebates, as amended by section 10 of part BB of chapter 56 of the laws of 2020, is amended to read as follows:

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

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

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

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

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

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

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

§ 5. The opening paragraph of paragraph (m) of subdivision 3 of section 461-l of the social services law, as amended by section 1 of part CC of chapter 57 of the laws of 2022, is amended to read as follows:

Beginning April first, two thousand [twenty-five] twenty-six, additional assisted living program beds shall be approved on a case by case basis whenever the commissioner of health is satisfied that public need exists at the time and place and under circumstances proposed by the applicant.

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

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

§ 7. Paragraph (a) of subdivision 1 of section 212 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential healthcare facilities, as amended by section 4 of part CC of chapter 57 of the laws of 2022, is amended to read as follows:

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

1996 reconciled data, and for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data as further reconciled to actual reported 2000 data, for 2001 based initially on reported 1995 reconciled data as further reconciled to actual reported 2001 data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 data, and for state fiscal years beginning on April 1, 2005, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2005, and for state fiscal years beginning on April 1, 2006, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2006, for state fiscal years beginning on and after April 1, 2007 through March 31, 2009, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2007 and 2008, respectively, for state fiscal years beginning on and after April 1, 2009, based initially on reported 2007 reconciled data, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and as further reconciled to actual reported data for 2009, for state fiscal years beginning on and after April 1, 2010, based initially on reported reconciled data from the base year two years prior to the payment year, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and further reconciled to actual reported data from such payment year, and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to an eligible public general hospital.

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

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

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

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

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

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

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

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

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

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

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

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

tion of the cost for high-utilization cases that exceed outlier thresholds of such payments.

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

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

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

§ 11. This act shall take effect immediately and:

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

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

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

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

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

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

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

§ 18. Section 4-a of part A of chapter 56 of the laws of 2013, amending chapter 59 of the laws of 2011 amending the public health law and

other laws relating to general hospital reimbursement for annual rates, as amended by section 32 of part B of chapter 57 of the laws of 2023, is amended to read as follows:

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

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

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

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

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

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

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

§ 22. Section 2 of chapter 633 of the laws of 2006, amending the public health law relating to the home based primary care for the elder-

ly demonstration project, as amended by section 1 of item OOO of subpart B of part XXX of chapter 58 of the laws of 2020, is amended to read as follows:

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

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

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

§ 24. Subdivisions (b) and (c) of section 8 of part BBB of chapter 56 of the laws of 2022, amending the public health law and other laws relating to permitting the commissioner of health to submit a waiver that expands eligibility for New York's basic health program and increases the federal poverty limit cap for basic health program eligibility from two hundred to two hundred fifty percent, as amended by section 3 of part J of chapter 57 of the laws of 2024, are amended to read as follows:

(b) section four of this act shall expire and be deemed repealed December 31, [2025] 2030; provided, however, the amendments to paragraph (c) of subdivision 1 of section 369-gg of the social services law made by such section of this act shall be subject to the expiration and reversion of such paragraph pursuant to section 2 of part H of chapter 57 of the laws of 2021 when upon such date, the provisions of section five of this act shall take effect; provided, however, the amendments to such paragraph made by section five of this act shall expire and be deemed repealed December 31, [2025] 2030;

(c) section six of this act shall take effect January 1, [2026] 2031; provided, however, the amendments to paragraph (c) of subdivision 1 of section 369-gg of the social services law made by such section of this act shall be subject to the expiration and reversion of such paragraph pursuant to section 2 of part H of chapter 57 of the laws of 2021 when upon such date, the provisions of section seven of this act shall take effect; and

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

10. The department of health shall establish or procure the services of an independent assessor or assessors no later than October 1, 2022, in a manner and schedule as determined by the commissioner of health, to take over from local departments of social services, Medicaid Managed Care providers, and Medicaid managed long term care plans performance of assessments and reassessments required for determining individuals' needs for personal care services, including as provided through the consumer directed personal assistance program, and other services or programs available pursuant to the state's medical assistance program as determined by such commissioner for the purpose of improving efficiency, quality, and reliability in assessment and to determine individuals' eligibility for Medicaid managed long term care plans. Notwithstanding the provisions of section one hundred sixty-three of the state finance law, or sections one hundred forty-two and one hundred forty-three of the economic development law, or any contrary provision of law, contracts may be entered or the commissioner may amend and extend the terms of a contract awarded prior to the effective date and entered into to conduct enrollment broker and conflict-free evaluation services for

the Medicaid program, if such contract or contract amendment is for the purpose of procuring such assessment services from an independent assessor. Contracts entered into, amended, or extended pursuant to this subdivision shall not remain in force beyond September 30, [2025] 2026.

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

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

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

PART C

Section 1. 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] the prescriber's 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.

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

§ 3. This act shall take effect January 1, 2026.

PART D

Section 1. The opening paragraph of subparagraph (i) of paragraph (i) of subdivision 35 of section 2807-c of the public health law, as amended

by section 5 of part D of chapter 57 of the laws of 2024, is amended to read as follows:

Notwithstanding any inconsistent provision of this subdivision or any other contrary provision of law and subject to the availability of federal financial participation, for each state fiscal year from July first, two thousand ten through December thirty-first, two thousand twenty-four; and for the calendar year January first, two thousand twenty-five through December thirty-first, two thousand twenty-five[; and for each calendar year thereafter], the commissioner shall make additional inpatient hospital payments up to the aggregate upper payment limit for inpatient hospital services after all other medical assistance payments, but not to exceed two hundred thirty-five million five hundred thousand dollars for the period July first, two thousand ten through March thirty-first, two thousand eleven, three hundred fourteen million dollars for each state fiscal year beginning April first, two thousand eleven, through March thirty-first, two thousand thirteen, and no less than three hundred thirty-nine million dollars for each state fiscal year until December thirty-first, two thousand twenty-four; and then from calendar year January first, two thousand twenty-five through December thirty-first, two thousand twenty-five[; and for each calendar year thereafter], to general hospitals, other than major public general hospitals, providing emergency room services and including safety net hospitals, which shall, for the purpose of this paragraph, be defined as having either: a Medicaid share of total inpatient hospital discharges of at least thirty-five percent, including both fee-for-service and managed care discharges for acute and exempt services; or a Medicaid share of total discharges of at least thirty percent, including both fee-for-service and managed care discharges for acute and exempt services, and also providing obstetrical services. Eligibility to receive such additional payments shall be based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year. Such payments shall be made as medical assistance payments for fee-for-service inpatient hospital services pursuant to title eleven of article five of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act and in accordance with the following:

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

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

(2) for the calendar years two thousand twenty-five and thereafter, the total distributions to major public general hospitals shall be subject to an aggregate reduction of one hundred thirteen million four hundred thousand dollars annually, provided that general hospitals operated by the New York city health and hospitals corporation as established by chapter one thousand sixteen of the laws of nineteen hundred sixty-nine, as amended, shall not receive distributions pursuant to this subdivision; and

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

PART E

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

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

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

(d-4) Notwithstanding paragraph (a) of this subdivision, the following medical assistance recipients shall not be eligible to participate in the managed care program authorized by this section or other care coordination model established by article forty-four of the public health law: any person who is permanently placed in a residential health care facility for a consecutive period of three months or more. However, nothing in this paragraph should be construed to apply to enrollees in the Medicaid Advantage Plus Program, developed to enroll persons in managed long-term care who are nursing home certifiable and who are dually eligible pursuant to section forty-four hundred three-f of the public health law. In implementing this provision, the department shall continue to support service delivery and outcomes that result in community living for enrollees.

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

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

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

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

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

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

(d) For the purposes of this subdivision a violation shall mean a determination by the commissioner that the managed care provider failed to act as required under the contract between the state and the managed care provider in place at the time of the failure, or applicable federal and state statutes, rules or regulations governing managed care providers. Each instance of a managed care provider failing to furnish necessary and/or required medical services or items to each enrollee shall be

a separate violation and each day that an ongoing violation continues shall be a separate violation.

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

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

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

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

PART F

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

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

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

(b) A child health insurance plan certified pursuant to section twenty-five hundred eleven of this chapter;

(c) Essential plan coverage certified pursuant to section three hundred sixty-nine-gg of the social services law;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The commissioner may waive a portion or all of either the interest or penalties, or both, assessed under this section if the commissioner determines, in their sole discretion, that the health plan has demonstrated that imposition of the full amount of the MCO provider tax pursuant to the timelines applicable under the approval letter has a high likelihood of creating an undue financial hardship for the health plan or creates a significant financial difficulty in providing needed services to Medicaid beneficiaries. In addition, the commissioner may waive a portion or all of either the interest or penalties, or both, assessed under this section if the commissioner determines, in their sole discretion, that the health plan did not have the information necessary from the department to pay the tax required in this section.

Waiver of some or all of the interest or penalties pursuant to this subdivision shall be conditioned on the health plan's agreement to make MCO provider tax payments on an alternative schedule developed by the department that takes into account the financial situation of the health plan and the potential impact on the delivery of services to Medicaid beneficiaries.

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

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

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

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

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

2. (a) The fund shall consist of monies received from the imposition of the centers for medicare and medicaid services-approved MCO provider tax established pursuant to section twenty-eight hundred seven-ff of the public health law, and all other monies appropriated, credited, or transferred thereto from any other fund or source pursuant to law.

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

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

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

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

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

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

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

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

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

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

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

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

§ 1-a. Notwithstanding any provision of law to the contrary, for the state fiscal years beginning April 1, 2023, and thereafter, Medicaid payments made for the operating component of hospital inpatient services shall be subject to a uniform rate increase of seven and one-half percent in addition to the increase contained in section one of this act, subject to the approval of the commissioner of health and the director of the budget. Notwithstanding any provision of law to the contrary, for the state fiscal years beginning April 1, 2023, and thereafter, Medicaid payments made for the operating component of hospital outpatient services shall be subject to a uniform rate increase of six and one-half percent in addition to the increase contained in section one of this act, subject to the approval of the commissioner of health and the director of the budget. Notwithstanding any provision of law to the contrary, for the period April 1, 2024 through March 31, 2025 Medicaid payments made for hospital services shall be increased by an aggregate amount of up to $525,000,000 in addition to the increase contained in sections one and one-b of this act subject to the approval of the commissioner of health and the director of the budget. Notwithstanding any provision of law to the contrary, for the state fiscal years beginning April 1, 2025, and thereafter, Medicaid payments made for the operating component of hospital outpatient services shall be subject to a uniform rate increase pursuant to a plan approved by the director of the budget in addition to the applicable increase contained in section one of this act and this section, subject to the approval of the commissioner of health and the director of the budget. Notwithstanding any provision of law to the contrary, for the period April 1, 2025, and thereafter, Medicaid payments made for hospital services shall be increased by an aggregate amount of up to $425,000,000 in addition to the increase contained in section one of this act and this section, subject to the approval of the commissioner of health and the director of the budget. Such rate increases shall be subject to federal financial participation and the provisions established under section one-f of this act.

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

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

standing any provision of law to the contrary, for state fiscal years beginning April 1, 2025, and thereafter Medicaid payments made for nursing home services shall be increased by an aggregate amount of up to $385,000,000 in addition to the increase contained in section one of this act and this section, subject to the approval of the commissioner of health and the director of the budget. Such rate increases shall be subject to federal financial participation and the provisions established under section one-f of this act.

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

§ 1-c. Notwithstanding any provision of law to the contrary, for the period April 1, 2025, and thereafter, Medicaid payments made for clinic service provided by federally qualified health centers and diagnostic and treatment centers shall be increased by an aggregate amount of up to $20,000,000 in addition to any applicable increase contained in section one of this act subject to the approval of the commissioner of health and the director of the budget. Such rate increases shall be subject to federal financial participation and the provisions established under section one-f of this act.

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

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

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

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

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

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

§ 8. This act shall take effect immediately; provided, however, that sections three, four, five, six and seven of this act shall be deemed to have been in full force and effect on and after April 1, 2025.

PART G

Section 1. Paragraph (a) of subdivision 1 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 1 of part K of chapter 57 of the laws of 2024, is amended and a new subdivision 9 is added to read as follows:

(a) The superintendent of financial services and the commissioner of health or their designee shall, from funds available in the hospital excess liability pool created pursuant to subdivision 5 of this section, purchase a policy or policies for excess insurance coverage, as authorized by paragraph 1 of subsection (e) of section 5502 of the insurance law; or from an insurer, other than an insurer described in section 5502 of the insurance law, duly authorized to write such coverage and actually writing medical malpractice insurance in this state; or shall purchase equivalent excess coverage in a form previously approved by the superintendent of financial services for purposes of providing equivalent excess coverage in accordance with section 19 of chapter 294 of the laws of 1985, for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, between July 1, 2018 and June 30, 2019, between July 1, 2019 and June 30, 2020, between July 1, 2020 and June 30, 2021, between July 1, 2021 and June 30, 2022, between July 1, 2022 and June 30, 2023, between July 1, 2023 and June 30, 2024, [and] between July 1, 2024 and

June 30, 2025, and between July 1, 2025 and June 30, 2026 or reimburse the hospital where the hospital purchases equivalent excess coverage as defined in subparagraph (i) of paragraph (a) of subdivision 1-a of this section for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, between July 1, 2018 and June 30, 2019, between July 1, 2019 and June 30, 2020, between July 1, 2020 and June 30, 2021, between July 1, 2021 and June 30, 2022, between July 1, 2022 and June 30, 2023, between July 1, 2023 and June 30, 2024, [and] between July 1, 2024 and June 30, 2025, and between July 1, 2025 and June 30, 2026 for physicians or dentists certified as eligible for each such period or periods pursuant to subdivision 2 of this section by a general hospital licensed pursuant to article 28 of the public health law; provided that no single insurer shall write more than fifty percent of the total excess premium for a given policy year; and provided, however, that such eligible physicians or dentists must have in force an individual policy, from an insurer licensed in this state of primary malpractice insurance coverage in amounts of no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants under that policy during the period of such excess coverage for such occurrences or be endorsed as additional insureds under a hospital professional liability policy which is offered through a voluntary attending physician ("channeling") program previously permitted by the superintendent of financial services during the period of such excess coverage for such occurrences. During such period, such policy for excess coverage or such equivalent excess coverage shall, when combined with the physician's or dentist's primary malpractice insurance coverage or coverage provided through a voluntary attending physician ("channeling") program, total an aggregate level of two million three hundred thousand dollars for each claimant and six million nine hundred thousand dollars for all claimants from all such policies with respect to occurrences in each of such years provided, however, if the cost of primary malpractice insurance coverage in excess of one million dollars, but below the excess medical malpractice insurance coverage provided pursuant to this act, exceeds the rate of nine percent per annum, then the required level of primary malpractice insurance coverage in excess of one million dollars for each claimant shall be in an amount of not less than the dollar amount of such coverage available at nine percent per annum; the required level of such coverage for all claimants under that policy shall be in an amount not less than

three times the dollar amount of coverage for each claimant; and excess coverage, when combined with such primary malpractice insurance coverage, shall increase the aggregate level for each claimant by one million dollars and three million dollars for all claimants; and provided further, that, with respect to policies of primary medical malpractice coverage that include occurrences between April 1, 2002 and June 30, 2002, such requirement that coverage be in amounts no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants for such occurrences shall be effective April 1, 2002.

(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, 2024, excess coverage shall be purchased by a physician or dentist directly from a provider of excess insurance coverage or equivalent excess coverage. At the conclusion of the policy period the superintendent of financial services and the commissioner of health or their designee shall, from funds available in the hospital excess liability pool created pursuant to subdivision 5 of this section, pay fifty percent of the premium to the provider of excess insurance coverage or equivalent excess coverage, and the remaining fifty percent shall be paid one year thereafter.

(b) Notwithstanding any law to the contrary, for any policy period beginning on or after July 1, 2025, excess coverage shall be purchased by a physician or dentist directly from a provider of excess insurance coverage or equivalent excess coverage. Such provider of excess insurance coverage or equivalent excess coverage shall bill, in a manner consistent with paragraph (f) of this subdivision, the physician or dentist for an amount equal to fifty percent of the premium for such coverage, as established pursuant to paragraph (d) of this subdivision, during the policy period. At the conclusion of the policy period the superintendent of financial services and the commissioner of health or their designee shall, from funds available in the hospital excess liability pool created pursuant to subdivision 5 of this section, pay half of the remaining fifty percent of the premium to the provider of excess insurance coverage or equivalent excess coverage, and the remaining twenty-five percent shall be paid one year thereafter. If the funds available in the hospital excess liability pool are insufficient to meet the percent of the costs of the excess coverage, the provisions of subdivision 8 of this section shall apply.

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

(d) The superintendent of financial services shall establish a rate consistent with subdivision 3 of this section that providers of excess insurance coverage or equivalent excess coverage will charge for such coverage for each policy period. For the policy period beginning July 1,

2025, 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, 2024.

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

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

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

§ 2. Subdivision 3 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 2 of part K of chapter 57 of the laws of 2024, is amended to read as follows:

(3)(a) The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, between July 1, 2018 and June 30, 2019, between July 1, 2019 and June 30, 2020, between July 1, 2020 and June 30, 2021, between July 1, 2021 and June 30, 2022, between July 1, 2022 and June 30, 2023, between July 1, 2023 and June 30, 2024, [and] between July 1, 2024 and June 30, 2025, and between July 1, 2025 and June 30, 2026 allocable to each general hospital for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage by such general hospital in accordance with subdivision 2 of this section, and may amend such determination and certification as necessary.

(b) The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance or equivalent excess coverage for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, between July 1, 2018 and June 30, 2019, between July 1, 2019 and June 30, 2020, between July 1, 2020 and June 30, 2021, between July 1, 2021 and June 30, 2022, between July 1, 2022 and June 30, 2023, between July 1, 2023 and June 30, 2024, [and] between July 1, 2024 and June 30, 2025<u>, and between July 1, 2025 and June 30, 2026</u> allocable to each general hospital for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage or equivalent excess coverage by such general hospital in accordance with subdivision 2 of this section, and may amend such determination and certification as necessary. The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the ratable share of such cost allocable to the period July 1, 1987 to December 31, 1987, to the period January 1, 1988 to June 30, 1988, to the period July 1, 1988 to December 31, 1988, to the period January 1, 1989 to June 30, 1989, to the period July 1, 1989 to December 31, 1989, to the period January 1, 1990 to June 30, 1990, to the period July 1, 1990 to December 31, 1990, to the period January 1, 1991 to June 30, 1991, to the period July 1, 1991 to December 31, 1991, to the period January 1, 1992 to June 30, 1992, to the period July 1, 1992 to December 31, 1992, to the period January 1, 1993 to June 30, 1993, to the period July 1, 1993 to December 31, 1993, to the period January 1, 1994 to June 30, 1994, to the period July 1, 1994 to December 31, 1994, to the period January 1, 1995 to June 30, 1995, to the period July 1, 1995 to December 31, 1995, to the period January 1, 1996 to June 30, 1996, to the period July 1, 1996 to December 31, 1996, to the period January 1, 1997 to June 30, 1997, to the period July 1, 1997 to December 31, 1997, to the period January 1, 1998 to June 30, 1998, to the period July 1, 1998 to December 31, 1998, to the period January 1, 1999 to June 30, 1999, to the period July 1, 1999 to December 31, 1999, to the period January 1, 2000 to June 30, 2000, to the period July 1, 2000 to December 31, 2000, to the period January 1, 2001 to June 30, 2001, to the period July 1, 2001 to June 30, 2002, to the period July 1, 2002 to June 30, 2003, to the period July 1, 2003 to June 30, 2004, to the period July 1, 2004 to June 30, 2005, to the period July 1, 2005 and June 30, 2006, to the period July 1, 2006 and June 30, 2007, to the period July 1, 2007 and June 30, 2008, to the

period July 1, 2008 and June 30, 2009, to the period July 1, 2009 and June 30, 2010, to the period July 1, 2010 and June 30, 2011, to the period July 1, 2011 and June 30, 2012, to the period July 1, 2012 and June 30, 2013, to the period July 1, 2013 and June 30, 2014, to the period July 1, 2014 and June 30, 2015, to the period July 1, 2015 and June 30, 2016, to the period July 1, 2016 and June 30, 2017, to the period July 1, 2017 to June 30, 2018, to the period July 1, 2018 to June 30, 2019, to the period July 1, 2019 to June 30, 2020, to the period July 1, 2020 to June 30, 2021, to the period July 1, 2021 to June 30, 2022, to the period July 1, 2022 to June 30, 2023, to the period July 1, 2023 to June 30, 2024, [and] to the period July 1, 2024 to June 30, 2025, and to the period July 1, 2025 to June 30, 2026.

§ 3. Paragraphs (a), (b), (c), (d) and (e) of subdivision 8 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 3 of part K of chapter 57 of the laws of 2024, are amended to read as follows:

(a) To the extent funds available to the hospital excess liability pool pursuant to subdivision 5 of this section as amended, and pursuant to section 6 of part J of chapter 63 of the laws of 2001, as may from time to time be amended, which amended this subdivision, are insufficient to meet the costs of excess insurance coverage or equivalent excess coverage for coverage periods during the period July 1, 1992 to June 30, 1993, during the period July 1, 1993 to June 30, 1994, during the period July 1, 1994 to June 30, 1995, during the period July 1, 1995 to June 30, 1996, during the period July 1, 1996 to June 30, 1997, during the period July 1, 1997 to June 30, 1998, during the period July 1, 1998 to June 30, 1999, during the period July 1, 1999 to June 30, 2000, during the period July 1, 2000 to June 30, 2001, during the period July 1, 2001 to October 29, 2001, during the period April 1, 2002 to June 30, 2002, during the period July 1, 2002 to June 30, 2003, during the period July 1, 2003 to June 30, 2004, during the period July 1, 2004 to June 30, 2005, during the period July 1, 2005 to June 30, 2006, during the period July 1, 2006 to June 30, 2007, during the period July 1, 2007 to June 30, 2008, during the period July 1, 2008 to June 30, 2009, during the period July 1, 2009 to June 30, 2010, during the period July 1, 2010 to June 30, 2011, during the period July 1, 2011 to June 30, 2012, during the period July 1, 2012 to June 30, 2013, during the period July 1, 2013 to June 30, 2014, during the period July 1, 2014 to June 30, 2015, during the period July 1, 2015 to June 30, 2016, during the period July 1, 2016 to June 30, 2017, during the period July 1, 2017 to June 30, 2018, during the period July 1, 2018 to June 30, 2019, during the period July 1, 2019 to June 30, 2020, during the period July 1, 2020 to June 30, 2021, during the period July 1, 2021 to June 30, 2022, during the period July 1, 2022 to June 30, 2023, during the period July 1, 2023 to June 30, 2024, [and] during the period July 1, 2024 to June 30, 2025, and during the period July 1, 2025 to June 30 2026 allocated or reallocated in accordance with paragraph (a) of subdivision 4-a of this section to rates of payment applicable to state governmental agencies, each physician or dentist for whom a policy for excess insurance coverage or equivalent excess coverage is purchased for such period shall be responsible for payment to the provider of excess insurance coverage or equivalent excess coverage of an allocable share of such insufficiency, based on the ratio of the total cost of such coverage for such physician to the sum of the total cost of such coverage for all physicians applied to such insufficiency.

(b) Each provider of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to June 30, 2020, or covering the period July 1, 2020 to June 30, 2021, or covering the period July 1, 2021 to June 30, 2022, or covering the period July 1, 2022 to June 30, 2023, or covering the period July 1, 2023 to June 30, 2024, or covering the period July 1, 2024 to June 30, 2025<u>, or covering the period July 1, 2025 to June 30, 2026</u> shall notify a covered physician or dentist by mail, mailed to the address shown on the last application for excess insurance coverage or equivalent excess coverage, of the amount due to such provider from such physician or dentist for such coverage period determined in accordance with paragraph (a) of this subdivision. Such amount shall be due from such physician or dentist to such provider of excess insurance coverage or equivalent excess coverage in a time and manner determined by the superintendent of financial services.

(c) If a physician or dentist liable for payment of a portion of the costs of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering

the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to June 30, 2020, or covering the period July 1, 2020 to June 30, 2021, or covering the period July 1, 2021 to June 30, 2022, or covering the period July 1, 2022 to June 30, 2023, or covering the period July 1, 2023 to June 30, 2024, or covering the period July 1, 2024 to June 30, 2025, or covering the period July 1, 2025 to June 30, 2026 determined in accordance with paragraph (a) of this subdivision fails, refuses or neglects to make payment to the provider of excess insurance coverage or equivalent excess coverage in such time and manner as determined by the superintendent of financial services pursuant to paragraph (b) of this subdivision, excess insurance coverage or equivalent excess coverage purchased for such physician or dentist in accordance with this section for such coverage period shall be cancelled and shall be null and void as of the first day on or after the commencement of a policy period where the liability for payment pursuant to this subdivision has not been met.

(d) Each provider of excess insurance coverage or equivalent excess coverage shall notify the superintendent of financial services and the commissioner of health or their designee of each physician and dentist eligible for purchase of a policy for excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to June 30, 2020, or covering the period July 1, 2020 to June 30, 2021, or covering the period July 1, 2021 to June 30, 2022, or covering the period July 1, 2022 to June 30, 2023, or covering the period July 1, 2023 to June 30, 2024, or covering the period July 1, 2024 to June 30, 2025, or covering the period July 1, 2025 to June 30, 2026 that has made payment to such provider of excess insurance coverage or equivalent excess coverage in accordance with paragraph (b) of this subdivision and of each physician and dentist who has failed, refused or neglected to make such payment.

(e) A provider of excess insurance coverage or equivalent excess coverage shall refund to the hospital excess liability pool any amount allocable to the period July 1, 1992 to June 30, 1993, and to the period July 1, 1993 to June 30, 1994, and to the period July 1, 1994 to June

30, 1995, and to the period July 1, 1995 to June 30, 1996, and to the period July 1, 1996 to June 30, 1997, and to the period July 1, 1997 to June 30, 1998, and to the period July 1, 1998 to June 30, 1999, and to the period July 1, 1999 to June 30, 2000, and to the period July 1, 2000 to June 30, 2001, and to the period July 1, 2001 to October 29, 2001, and to the period April 1, 2002 to June 30, 2002, and to the period July 1, 2002 to June 30, 2003, and to the period July 1, 2003 to June 30, 2004, and to the period July 1, 2004 to June 30, 2005, and to the period July 1, 2005 to June 30, 2006, and to the period July 1, 2006 to June 30, 2007, and to the period July 1, 2007 to June 30, 2008, and to the period July 1, 2008 to June 30, 2009, and to the period July 1, 2009 to June 30, 2010, and to the period July 1, 2010 to June 30, 2011, and to the period July 1, 2011 to June 30, 2012, and to the period July 1, 2012 to June 30, 2013, and to the period July 1, 2013 to June 30, 2014, and to the period July 1, 2014 to June 30, 2015, and to the period July 1, 2015 to June 30, 2016, to the period July 1, 2016 to June 30, 2017, and to the period July 1, 2017 to June 30, 2018, and to the period July 1, 2018 to June 30, 2019, and to the period July 1, 2019 to June 30, 2020, and to the period July 1, 2020 to June 30, 2021, and to the period July 1, 2021 to June 30, 2022, and to the period July 1, 2022 to June 30, 2023, and to the period July 1, 2023 to June 30, 2024, and to the period July 1, 2024 to June 30, 2025, and to the period July 1, 2025 to June 30, 2026 received from the hospital excess liability pool for purchase of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, and covering the period July 1, 1993 to June 30, 1994, and covering the period July 1, 1994 to June 30, 1995, and covering the period July 1, 1995 to June 30, 1996, and covering the period July 1, 1996 to June 30, 1997, and covering the period July 1, 1997 to June 30, 1998, and covering the period July 1, 1998 to June 30, 1999, and covering the period July 1, 1999 to June 30, 2000, and covering the period July 1, 2000 to June 30, 2001, and covering the period July 1, 2001 to October 29, 2001, and covering the period April 1, 2002 to June 30, 2002, and covering the period July 1, 2002 to June 30, 2003, and covering the period July 1, 2003 to June 30, 2004, and covering the period July 1, 2004 to June 30, 2005, and covering the period July 1, 2005 to June 30, 2006, and covering the period July 1, 2006 to June 30, 2007, and covering the period July 1, 2007 to June 30, 2008, and covering the period July 1, 2008 to June 30, 2009, and covering the period July 1, 2009 to June 30, 2010, and covering the period July 1, 2010 to June 30, 2011, and covering the period July 1, 2011 to June 30, 2012, and covering the period July 1, 2012 to June 30, 2013, and covering the period July 1, 2013 to June 30, 2014, and covering the period July 1, 2014 to June 30, 2015, and covering the period July 1, 2015 to June 30, 2016, and covering the period July 1, 2016 to June 30, 2017, and covering the period July 1, 2017 to June 30, 2018, and covering the period July 1, 2018 to June 30, 2019, and covering the period July 1, 2019 to June 30, 2020, and covering the period July 1, 2020 to June 30, 2021, and covering the period July 1, 2021 to June 30, 2022, and covering the period July 1, 2022 to June 30, 2023 for, and covering the period July 1, 2023 to June 30, 2024, and covering the period July 1, 2024 to June 30, 2025, and covering the period July 1, 2025 to June 30, 2026 a physician or dentist where such excess insurance coverage or equivalent excess coverage is cancelled in accordance with paragraph (c) of this subdivision.

§ 4. Section 40 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and

professional medical conduct, as amended by section 4 of part K of chapter 57 of the laws of 2024, is amended to read as follows:

§ 40. The superintendent of financial services shall establish rates for policies providing coverage for physicians and surgeons medical malpractice for the periods commencing July 1, 1985 and ending June 30, [2025] 2026; provided, however, that notwithstanding any other provision of law, the superintendent shall not establish or approve any increase in rates for the period commencing July 1, 2009 and ending June 30, 2010. The superintendent shall direct insurers to establish segregated accounts for premiums, payments, reserves and investment income attributable to such premium periods and shall require periodic reports by the insurers regarding claims and expenses attributable to such periods to monitor whether such accounts will be sufficient to meet incurred claims and expenses. On or after July 1, 1989, the superintendent shall impose a surcharge on premiums to satisfy a projected deficiency that is attributable to the premium levels established pursuant to this section for such periods; provided, however, that such annual surcharge shall not exceed eight percent of the established rate until July 1, [2025] 2026, at which time and thereafter such surcharge shall not exceed twenty-five percent of the approved adequate rate, and that such annual surcharges shall continue for such period of time as shall be sufficient to satisfy such deficiency. The superintendent shall not impose such surcharge during the period commencing July 1, 2009 and ending June 30, 2010. On and after July 1, 1989, the surcharge prescribed by this section shall be retained by insurers to the extent that they insured physicians and surgeons during the July 1, 1985 through June 30, [2025] 2026 policy periods; in the event and to the extent physicians and surgeons were insured by another insurer during such periods, all or a pro rata share of the surcharge, as the case may be, shall be remitted to such other insurer in accordance with rules and regulations to be promulgated by the superintendent. Surcharges collected from physicians and surgeons who were not insured during such policy periods shall be apportioned among all insurers in proportion to the premium written by each insurer during such policy periods; if a physician or surgeon was insured by an insurer subject to rates established by the superintendent during such policy periods, and at any time thereafter a hospital, health maintenance organization, employer or institution is responsible for responding in damages for liability arising out of such physician's or surgeon's practice of medicine, such responsible entity shall also remit to such prior insurer the equivalent amount that would then be collected as a surcharge if the physician or surgeon had continued to remain insured by such prior insurer. In the event any insurer that provided coverage during such policy periods is in liquidation, the property/casualty insurance security fund shall receive the portion of surcharges to which the insurer in liquidation would have been entitled. The surcharges authorized herein shall be deemed to be income earned for the purposes of section 2303 of the insurance law. The superintendent, in establishing adequate rates and in determining any projected deficiency pursuant to the requirements of this section and the insurance law, shall give substantial weight, determined in his discretion and judgment, to the prospective anticipated effect of any regulations promulgated and laws enacted and the public benefit of stabilizing malpractice rates and minimizing rate level fluctuation during the period of time necessary for the development of more reliable statistical experience as to the efficacy of such laws and regulations affecting medical, dental or podiatric malpractice enacted or promulgated in 1985,

1986, by this act and at any other time. Notwithstanding any provision of the insurance law, rates already established and to be established by the superintendent pursuant to this section are deemed adequate if such rates would be adequate when taken together with the maximum authorized annual surcharges to be imposed for a reasonable period of time whether or not any such annual surcharge has been actually imposed as of the establishment of such rates.

§ 5. Section 5 and subdivisions (a) and (e) of section 6 of part J of chapter 63 of the laws of 2001, amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 5 of part K of chapter 57 of the laws of 2024, are amended to read as follows:

§ 5. The superintendent of financial services and the commissioner of health shall determine, no later than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15, 2013, June 15, 2014, June 15, 2015, June 15, 2016, June 15, 2017, June 15, 2018, June 15, 2019, June 15, 2020, June 15, 2021, June 15, 2022, June 15, 2023, June 15, 2024, [and] June 15, 2025<u>, and June 15, 2026</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, or July 1, 2022 to June 30, 2023, or July 1, 2023 to June 30, 2024, or July 1, 2024 to June 30, 2025<u>, or July 1, 2025 to June 30, 2026</u> as applicable.

(a) This section shall be effective only upon a determination, pursuant to section five of this act, by the superintendent of financial services and the commissioner of health, and a certification of such determination to the state director of the budget, the chair of the senate committee on finance and the chair of the assembly committee on ways and means, that the amount of funds in the hospital excess liability pool, created pursuant to section 18 of chapter 266 of the laws of 1986, is insufficient for purposes of purchasing excess insurance coverage for eligible participating physicians and dentists during the period July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30, 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30, 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30, 2018, or July 1, 2018 to June 30, 2019, or July 1, 2019 to June 30, 2020, or July 1, 2020 to June 30, 2021, or July 1, 2021 to June 30,

2022, or July 1, 2022 to June 30, 2023, or July 1, 2023 to June 30, 2024, or July 1, 2024 to June 30, 2025, or July 1, 2025 to June 30, 2026 as applicable.

(e) The commissioner of health shall transfer for deposit to the hospital excess liability pool created pursuant to section 18 of chapter 266 of the laws of 1986 such amounts as directed by the superintendent of financial services for the purchase of excess liability insurance coverage for eligible participating physicians and dentists for the policy year July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, as applicable, and the cost of administering the hospital excess liability pool for such applicable policy year, pursuant to the program established in chapter 266 of the laws of 1986, as amended, no later than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15, 2013, June 15, 2014, June 15, 2015, June 15, 2016, June 15, 2017, June 15, 2018, June 15, 2019, June 15, 2020, June 15, 2021, June 15, 2022, June 15, 2023, June 15, 2024, [and] June 15, 2025, and June 15, 2026 as applicable.

§ 6. Section 20 of part H of chapter 57 of the laws of 2017, amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions thereto, as amended by section 6 of part K of chapter 57 of the laws of 2024, is amended to read as follows:

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

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

PART H

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(v) may supplement an existing research project;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[(r)] (n) "Weighted resident count" means a teaching general hospital's total number of residents as of July first, nineteen hundred ninety-five, including residents in affiliated non-hospital ambulatory settings, reported to the commissioner. Such resident counts shall reflect the weights established in accordance with rules and regulations adopted by the state hospital review and planning council and approved by the commissioner for purposes of implementing subdivision twenty-five of section twenty-eight hundred seven-c of this article and in effect on July first, nineteen hundred ninety-five. Such weights shall not be applied to specialty hospitals, specified by the commissioner, whose primary care mission is to engage in research, training and clinical care in specialty eye and ear, special surgery, orthopedic, joint disease, cancer, chronic care or rehabilitative services.

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

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

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

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

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

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

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

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

(i) for a hospital for which an adjustment amount pursuant to paragraph [(s)] (o) of this subdivision does not apply, the amount received by the hospital pursuant to paragraph (a) of subdivision five of this section attributable to the period January first, two thousand three through December thirty-first, two thousand three, or

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

the hospital's adjustment amount, the difference between the distribution amount and the adjustment amount.

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

(a) Up to thirty-one million dollars annually for the periods January first, two thousand through December thirty-first, two thousand three, and up to twenty-five million dollars plus the sum of the amounts specified in paragraph [(n)] (k) of subdivision one of this section for the period January first, two thousand five through December thirty-first, two thousand five, and up to thirty-one million dollars annually for the period January first, two thousand six through December thirty-first, two thousand seven, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section for supplemental distributions in each such region to be made by the commissioner to consortia and teaching general hospitals in accordance with a distribution methodology developed in consultation with the council and specified in rules and regulations adopted by the commissioner.

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

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

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

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

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

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

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

(C) If the dollar amount for the total number of clinical research positions in the region calculated pursuant to clause (B) of this subparagraph exceeds the total amount appropriated for purposes of this paragraph, including clinical research positions that continue from and were funded in prior distribution periods, the commissioner shall eliminate one-half of the clinical research positions submitted by each consortium or teaching general hospital rounded down to the nearest one position. Such reduction shall be repeated until the dollar amount for the total number of clinical research positions in the region does not

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

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

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

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

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

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

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

(I) For each clinical research position, information on the type, scope, training objectives, institutional support, clinical research experience of the sponsor-mentor, plans for submitting research outcomes to peer reviewed journals and at scientific meetings, including a meet-

ing 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 thou-

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

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

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

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

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

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

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

[(d)] (c) Physician practice support. Four million nine hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, four million nine hundred thousand dollars annually for the period January first, two thousand nine through December thirty-first, two thousand ten, one million two hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, four million three hundred thousand dollars each state fiscal year for the

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

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

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

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

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

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

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

[(f)] (e) Study on physician workforce. Five hundred ninety thousand dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, one hundred forty-eight thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, five hundred sixteen thousand dollars each state fiscal year for the period April first, two

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

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

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

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

physician practice support program pursuant to paragraph [(d)] (c) of subdivision five-a of this section, shall be subject to the following changes:

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

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

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

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

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

(xvi) provided further, however, for periods prior to July first, two thousand nine, amounts set forth in this paragraph shall be reduced by an amount equal to the actual distribution reductions for all facilities pursuant to paragraph [(s)] (o) of subdivision one of section twenty-eight hundred seven-m of this article.

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

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

§ 6. Article 27-H of the public health law, as added by chapter 550 of the laws of 1998, is REPEALED.

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

PART I

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

1. The department is hereby authorized and directed to design, implement and maintain an electronic death registration system for collecting, storing, recording, transmitting, amending, correcting and authenticating information, as necessary and appropriate to complete a death registration, and to generate such documents as determined by the department in relation to a death occurring in this state. As part of the design and implementation of the system established by this section, the department shall consult with all persons authorized to use such

system to the extent practicable and feasible. [The payment referenced in subdivision five of this section shall be collected for each burial or removal permit issued on or after the effective date of this section from the licensed funeral director or undertaker to whom such permit is issued, in the manner specified by the department and shall be used solely for the purpose set forth in subdivision five of this section.] Except as specifically provided in this section, the existing general duties of, and remuneration received by, local registrars in accepting and filing certificates of death and issuing burial and removal permits pursuant to any statute or regulation shall be maintained, and not altered or abridged in any way by this section.

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

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

PART J

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

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

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

PART K

Section 1. Subdivisions 1, 2, 3, 4, 5 and 6 of section 2806-a of the public health law, as added by section 50 of part E of chapter 56 of the laws of 2013, paragraph (g) of subdivision 1 as added by section 7, paragraph (a) of subdivision 2 as amended by section 8, and subparagraph (iii) of paragraph (c) of subdivision 5 as amended by section 9 of part K of chapter 57 of the laws of 2015, are amended to read as follows:

1. For the purposes of this section:

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

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

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

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

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

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

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

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

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

2. (a) In the event that: (i) a facility seeks extraordinary financial assistance [and] or the commissioner finds that the facility is experiencing serious financial instability that is jeopardizing existing or continued access to essential services within the community[,]; or (ii) the commissioner finds that there are conditions within the facility that seriously endanger the life, health or safety of residents or patients[, the commissioner may appoint a temporary operator to assume sole control and sole responsibility for the operations of that facility,]; or (iii) the commissioner finds that there has been an improper delegation of management authority by the governing authority or operator of a general hospital[,]; the commissioner [shall] may appoint a temporary operator to assume sole control and sole responsibility for the operations of that facility. The appointment of the temporary operator shall be effectuated pursuant to this section and shall be in addition to any other remedies provided by law.

(b) The established operator of a facility may at any time request the commissioner to appoint a temporary operator. Upon receiving such a request, the commissioner may, if [he or she determines] they determine that such an action is necessary to restore or maintain the provision of

quality care to the residents or patients, or alleviate the facility's financial instability, enter into an agreement with the established operator for the appointment of a temporary operator to assume sole control and sole responsibility for the operations of that facility.

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

(b) The temporary operator shall use [his or her] their best efforts to implement the work plan provided to the commissioner, if applicable, and to correct or eliminate any deficiencies or financial instability in the facility and to promote the quality and accessibility of health care services in the community served by the facility. The temporary operator's authority shall include, but not be limited to, hiring or firing of the facility administrator and other key management employees; maintenance and control of the books and records; authority over the disposition of assets and the incurring of liabilities on behalf of the facility; and the adoption and enforcement of policies regarding the operation of the facility. Such correction or elimination of deficiencies or serious financial instability shall not include major alterations of the physical structure of the facility. During the term of [his or her] their appointment, the temporary operator shall have the sole authority to direct the management of the facility in all aspects of operation and shall be afforded full access to the accounts and records of the facility. The temporary operator shall, during this period, operate the facility in such a manner as to promote safety and the quality and accessibility of health care services or residential care in the community served by the facility. The temporary operator shall have the power to let contracts therefor or incur expenses on behalf of the facility, provided that where individual items of repairs, improvements or supplies exceed ten thousand dollars, the temporary operator shall obtain price quotations from at least three reputable sources. The temporary operator shall not be required to file any bond. No security interest in any real or personal property comprising the facility or contained within the facility, or in any fixture of the facility, shall be impaired or diminished in priority by the temporary operator. Neither the temporary operator nor the department shall engage in any activity that constitutes a confiscation of property without the payment of fair compensation.

4. The temporary operator shall be entitled to a reasonable fee, as determined by the commissioner, and necessary expenses incurred during [his or her] their performance as temporary operator, to be paid from the revenue of the facility. The temporary operator shall collect incoming payments from all sources and apply them to the reasonable fee and to costs incurred in the performance of [his or her] their functions as

temporary operator in correcting deficiencies and causes of serious financial instability. The temporary operator shall be liable only in [his or her] their capacity as temporary operator for injury to person and property by reason of conditions of the facility in a case where an established operator would have been liable; [he or she] they shall not have any liability in [his or her] their personal capacity, except for gross negligence and intentional acts.

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

(b) Upon the completion of the [two ninety-day] up to three one hundred eighty-day terms referenced in paragraph (a) of this subdivision,

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

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

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

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

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

(iii) recommended actions for the ongoing operation of the facility subsequent to the term of the temporary operator including recommendations regarding the proper management of the facility and ongoing agreements with individuals or entities with proper delegation of management authority; and

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

Each report pursuant to this paragraph shall be reviewed by the commissioner, who may consult with the temporary operator and the established

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

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

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

(b) Should the commissioner and the established operator be unable to establish a plan of correction pursuant to paragraph (a) of this subdivision, or should the established operator fail to respond to the commissioner's initial notification, a temporary operator shall be appointed as soon as is practicable and shall operate pursuant to the provisions of this section.

(c) The established operator shall be afforded an opportunity for an administrative hearing on the commissioner's determination to appoint a temporary operator. [Such administrative hearing shall occur prior to such appointment, except that the hearing shall not be required prior to the appointment of the temporary operator pursuant to clause (ii) of paragraph (a) of subdivision two of this section if the commissioner has determined that the immediate appointment of a temporary operator is necessary because public health or safety is in imminent danger or there exists any condition or practice or a continuing pattern of conditions or practices which poses imminent danger to the health or safety of any

patient or resident of the facility.] An administrative hearing as provided for under this paragraph shall begin no later than [sixty] thirty days from the date [of the notice to the established operator] the temporary operator is appointed and shall not be extended without the consent of both parties. Any such hearing shall be strictly limited to the issue of whether the determination of the commissioner to appoint a temporary operator is supported by substantial evidence. A [copy of the] decision shall be made and sent to the [established operator] parties no later than ten business days after completion of the hearing.

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

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

PART L

Section 1. Section 18-c of the public health law, as added by section 4 of part O of chapter 57 of the laws of 2024, is amended to read as follows:

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

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

PART M

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

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

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

(b) Unreimbursed costs from Medicaid;

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

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

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

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

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

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

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

§ 2. This act shall take effect October 1, 2025. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

PART N

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

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

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

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

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

§ 3. This act shall take effect immediately.

PART O

Section 1. Subdivision (b) of schedule I of section 3306 of the public health law is amended by adding eighteen new paragraphs 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109 and 110 to read as follows:

(93) 1-methoxy-3-{4-(2-methoxy-2-phenylethyl)piperazin-1-yl}-1-phenylpropan-2-ol. Other name: Zipeprol.

(94) N,N-diethyl-2-(2-(4-methoxybenzyl)-5-nitro-1H-benzimidazol-1-yl)ethan-1-amine. Other name: Metonitazene.

(95) N-(3-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)propionamide. Other name: meta-Fluorofentanyl.

(96) N-(3-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide. Other name: meta-Fluoroisobutyryl fentanyl.

(97) N-(4-methoxyphenyl)-N-(1-phenethylpiperidin-4-yl)furan-2-carboxamide. Other name: para-Methoxyfuranylfentanyl.

(98) N-(1-phenethylpiperidin-4-yl)-N-phenylfuran-3-carboxamide. Other name: 3-Furanyl fentanyl.

(99) N-(1-(2,5-dimethoxyphenethyl)piperidin-4-yl)-N-phenylpropionamide. Other name: 2',5'-Dimethoxyfentanyl.

(100) 3-methyl-N-(1-phenethylpiperidin-4-yl)-N-phenylbutanamide. Other name: Isovaleryl fentanyl.

(101) N-(2-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)furan-2-carboxamide. Other name: ortho-Fluorofuranylfentanyl.

(102) 2-methyl-N-(1-phenethylpiperidin-4-yl)-N-phenylbutanamide. Other name: alpha'-Methyl butyryl fentanyl.

(103) N-(4-methylphenyl)-N-(1-phenethylpiperidin-4-yl)cyclopropanecarboxamide. Other name: para-Methylcyclopropyl fentanyl.

(104) 2-(2-(4-ethoxybenzyl)-1H-benzimidazol-1-yl)-N,N-diethylethan-1-amine. Other names: Etodesnitazene; Etazene.

(105) 2-(4-ethoxybenzyl)-5-nitro-1-(2-(pyrrolidin-1-yl)ethyl)-1H-benzimidazole. Other names: N-pyrrolidinoetonitazene; Etonitazepyne.

(106) N,N-diethyl-2-(5-nitro-2-(4-propoxybenzyl)-1H-benzimidazol-1-yl)ethan-1-amine. Other name: Protonitazene.

(107) 1-(2-Methyl-4-(3-phenylprop-2-en-1-yl)piperazin-1-yl)butan-1-one. Other name: 2-Methyl AP-237.

(108) 2-(2-(4-butoxybenzyl)-5-nitro-1H-benzimidazol-1-yl)-N,N-diethylethan-1-amine. Other name: Butonitazene.

(109) N,N-diethyl-2-(2-(4-fluorobenzyl)-5-nitro-1H-benzimidazol-1-yl) ethan-1-amine. Other name: Flunitazene.

(110) N,N-diethyl-2-(2-(4-methoxybenzyl)-1H-benzimidazol-1-yl)ethan-1-amine). Other name: Metodesnitazene.

§ 2. Paragraphs 11 and 36 of subdivision (d) of schedule I of section 3306 of the public health law, paragraph 11 as added by chapter 664 of the laws of 1985 and paragraph 36 as added by section 5 of part BB of chapter 57 of the laws of 2018, are amended to read as follows:

(11) [Ibogane] Ibogaine. Some trade and other names: [7-ethyl-6, 6&, 7, 8, 9, 10, 12, 13-octahydro-2-methoxy-6, 9-methano-5h-pyrido {1',2':1,2} azepino {5,4-b} indole: tabernanthe iboga.] 7-Ethyl-6,6&,7,8,9,10,12,13-octahydro-2-methoxy-6, 9-methano-5H-pyrido{1',2':1,2} azepino {5,4-b} indole; Tabernanthe iboga.

(36) 5-methoxy-N,N-dimethyltryptamine. Some trade or other names: 5-methoxy-3-{2-(dimethylamino)ethyl}indole; 5-MeO-DMT.

§ 3. Subdivision (d) of schedule I of section 3306 of the public health law is amended by adding nineteen new paragraphs 32, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55 and 56 to read as follows:

(32) 4-methyl-N-ethylcathinone. Some trade or other names: 4-MEC.

(39) 4-methyl-alpha-pyrrolidinopropiophenone. Some trade or other names: 4-MePPP.

(40) Alpha-pyrrolidinopentiophenone. Some trade or other names: @-PVP.

(41) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)butan-1-one. Some trade or other names: Butylone; bk-MBDB.

(42) 2-(methylamino)-1-phenylpentan-1-one. Some trade or other names: Pentedrone.

(43) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)pentan-1-one. Some trade or other names: Pentylone; bk-MBDP.

(44) 1-(naphthalen-2-yl)-2-(pyrrolidin-1-yl)pentan-1-one. Some trade or other names: Naphyrone.

(45) Alpha-pyrrolidinobutiophenone. Some trade or other names: @-PBP.

(46) 1-(1,3-benzodioxol-5-yl)-2-(ethylamino)propan-1-one. Some trade or other names: Ethylone.

(47) N-ethylpentylone. Some trade or other names: Ephylone; 1-(1,3-benzodioxol-5-yl)-2-(ethylamino)pentan-1-one).

(48) 1-(4-methoxyphenyl)-N-methylpropan-2-amine. Some trade or other names: Para-methoxymethamphetamine; PMMA.

(49) N-Ethylhexedrone. Some trade or other names: @-ethylaminohexanophenone; 2-(ethylamino)-1-phenylhexan-1-one.

(50) alpha-Pyrrolidinohexanophenone. Some trade or other names: @-PHP; 1-phenyl-2-(pyrrolidin-1-yl)hexan-1-one.

(51) 4-Methyl-alpha-ethylaminopentiophenone. Some trade or other names: 4-MEAP; 2-(ethylamino)-1-(4-methylphenyl)pentan-1-one.

(52) 4'-Methyl-alpha-pyrrolidinohexiophenone. Some trade or other names: MPHP; 4'-methyl-alpha-pyrrolidinohexanophenone; 1-(4-methylphenyl)-2-(pyrrolidin-1-yl)hexan-1-one.

(53) alpha-Pyrrolidinoheptaphenone. Some trade or other names: PV8; 1-phenyl-2-(pyrrolidin-1-yl)heptan-1-one.

(54) 4'-Chloro-alpha-pyrrolidinovalerophenone. Some trade or other names: 4-chloro-@-PVP; 4'-Chloro-alpha-pyrrolidinopentiophenone; 1-(4-chlorophenyl)-2-(pyrrolidin-1-yl)pentan-1-one.

(55) 2-(ethylamino)-2-(3-methoxyphenyl)cyclohexan-1-one. Some trade or other names: Methoxetamine; MXE.

(56) 1-(1,3-benzodioxol-5-yl)-2-(ethylamino)butan-1-one. Some trade or other names: Eutylone; bk-EBDB.

§ 4. Subdivision (e) of schedule I of section 3306 of the public health law is amended by adding five new paragraphs 7, 8, 9, 10 and 11 to read as follows:

(7) 4-(2-chlorophenyl)-2-ethyl-9-methyl-6H-thieno{3,2-f}{1,2,4}triazolo{4,3-a}{1,4}diazepine. Some trade or other names: Etizolam.

(8) 8-chloro-6-(2-fluorophenyl)-1-methyl-4H-benzo{f}{1,2,4}triazolo{4,3-a}{1,4}diazepine. Some trade or other names: Flualprazolam.

(9) 6-(2-chlorophenyl)-1-methyl-8-nitro-4H-benzo{f}{1,2,4}triazolo{4,3-a}{1,4}diazepine. Some trade or other names: Clonazolam.

(10) 8-bromo-6-(2-fluorophenyl)-1-methyl-4H-benzo{f}{1,2,4}triazolo{4,3-a}{1,4}diazepine. Some trade or other names: Flubromazolam.

(11) 7-chloro-5-(2-chlorophenyl)-1-methyl-1,3-dihydro-2H-benzo{e}{1,4}diazepin-2-one. Some trade or other names: Diclazepam.

§ 5. Paragraphs 13 and 14 of subdivision (f) of schedule I of section 3306 of the public health law, as added by chapter 341 of the laws of 2013, are amended and five new paragraphs 25, 26, 27, 28, and 29 are added to read as follows:

(13) 3-Fluoromethcathinone. Some trade or other names: 3-fluoro-N-methylcathinone; 3-FMC.

(14) 4-Fluoromethcathinone. Some trade or other names: 4-fluoro-N-methylcathinone; 4-FMC; Flephedrone.

(25) 7-{(10,11-dihydro-5H-dibenzo{a,d}cyclohepten-5-yl)amino}heptanoic acid. Other name: Amineptine.

(26) N-phenyl-N'-(3-(1-phenylpropan-2-yl)-1,2,3-oxadiazol-3-ium-5-yl)carbamimidate. Other name: Mesocarb.

(27) N-methyl-1-(thiophen-2-yl)propan-2-amine. Other name: Methiopropamine.

(28) 4,4'-Dimethylaminorex. Some trade or other names: 4,4'-DMAR; 4,5-dihydro-4-methyl-5-(4-methylphenyl)-2-oxazolamine; 4-methyl-5-(4-methylphenyl)-4,5-dihydro-1,3-oxazol-2-amine.

(29) Ethyl 2-phenyl-2-(piperidin-2-yl)acetate. Other name: Ethylphenidate.

§ 6. Paragraphs 2, 6 and 10 of subdivision (g) of schedule I of section 3306 of the public health law, as added by section 7 of part BB of chapter 57 of the laws of 2018, are amended to read as follows:

(2) [{1-(5-fluro-pentyl)-1H-indol-3-yl}(2,2,3,3-tetramethylcyclopropyl) methanone.] {1-(5-fluoro-pentyl)-1H-indol-3-yl}(2,2,3,3-tetramethylcyclopropyl)methanone. Some trade names or other names: 5-fluoro-UR-144[,]; XLR11.

(6) [N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)-1H-indazo[-]le-3-carboxamide.] N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)-1H-indazole-3-carboxamide. Some trade or other names: AB- FUBINACA.

(10) [{1-(5-fluoropentyl)-1H-indazol-3-yl}(naphthalen-1-yl)methanone.] {1-(5-fluoropentyl)-1H-indazol-3-yl}(naphthalen-1-yl)methanone. Some trade or other names: THJ-2201.

§ 7. Subdivision (g) of schedule I of section 3306 of the public health law is amended by adding nineteen new paragraphs 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28 and 29 to read as follows:

(11) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)-1H-indazole-3-carboxamide. Some trade or other names: MAB-CHMINACA; ADB-CHMINACA.

(12) methyl 2-(1-(4-fluorobenzyl)-1H-indazole-3-carboxamido)-3-methylbutanoate. Some trade or other names: FUB-AMB; MMB-FUBINACA; AMB-FUBINACA.

(13) methyl 2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido)-3,3-dimethylbutanoate. Some trade or other names: MDMB-CHMICA; MMB-CHMINACA.

(14) methyl 2-(1-(4-fluorobenzyl)-1H-indazole-3-carboxamido)-3,3-dimethylbutanoate. Some trade or other names: MDMB-FUBINACA.

(15) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)-1H-indazole-3-carboxamide. Some trade or other names: ADB-FUBINACA.

(16) N-(adamantan-1-yl)-1-(5-fluoropentyl)-1H-indazole-3-carboxamide. Some trade or other names: 5F-APINACA; 5F-AKB48.

(17) methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3-methylbutanoate. Some trade or other names: 5F-AMB.

(18) methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3,3-dimethylbutanoate. Some trade or other names: 5F-ADB; 5F-MDMB-PINACA.

(19) Naphthalen-1-yl 1-(5-fluoropentyl)-1H-indole-3-carboxylate. Some trade or other names: NM2201; CBL2201.

(20) N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)-1H-indazole-3-carboxamide. Some trade or other names: 5F-AB-PINACA.

(21) 1-(4-cyanobutyl)-N-(2-phenylpropan-2-yl)-1H-indazole-3-carboxamide. Some trade or other names: 4-CN-CUMYL-BUTINACA; 4-cyano-CUMYL-BUTINACA; 4-CN-CUMYL BINACA; CUMYL-4CN-BINACA; SGT-78.

(22) methyl2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido)-3-methylbutanoate. Some trade or other names: MMB-CHMICA; AMB-CHMICA.

(23) 1-(5-fluoropentyl)-N-(2-phenylpropan-2-yl)-1H-pyrrolo{2,3-b}pyridine-3-carboxamide. Some trade or other names: 5F-CUMYL-P7AICA.

(24) methyl 2-(1-(4-fluorobutyl)-1H-indazole-3-carboxamido)-3,3-dimethylbutanoate. Some trade or other names: 4F-MDMB-BINACA; 4F-MDMB-BUTINACA.

(25) ethyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3,3-dimethylbutanoate. Some trade or other names: 5F-EDMB-PINACA.

(26) methyl2-(1-(5-fluoropentyl)-1H-indole-3-carboxamido)-3,3-dimethylbutanoate. Some trade or other names: 5F-MDMB-PICA; 5F-MDMB-2201.

(27) N-(adamantan-1-yl)-1-(4-fluorobenzyl)-1H-indazole-3-carboxamide. Some trade or other names: FUB-AKB48; FUB-APINACA; AKB48 N-(4-FLUOROBENZYL).

(28) 1-(5-fluoropentyl)-N-(2-phenylpropan-2-yl)-1H-indazole-3-carboxamide. Some trade or other names: 5F-CUMYL-PINACA; SGT-25.

(29) (1-(4-fluorobenzyl)-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl)methanone. Some trade or other names: FUB-144.

§ 8. Paragraph 1 of subdivision (b) of schedule II of section 3306 of the public health law, as amended by section 1 of part C of chapter 447 of the laws of 2012, is amended to read as follows:

(1) Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate, excluding apomorphine, dextrorphan, nalbuphine, naldemedine, nalmefene, naloxegol, naloxone, [and] 6&-naltrexol, naltrexone, and samidorphan, and their respective salts, but including the following:

1. Raw opium.
2. Opium extracts.
3. Opium fluid.
4. Powdered opium.
5. Granulated opium.
6. Tincture of opium.
7. Codeine.
8. Ethylmorphine.
9. Etorphine hydrochloride.
10. Hydrocodone (also known as dihydrocodeinone).
11. Hydromorphone.

12. Metopon.
13. Morphine.
14. Oxycodone.
15. Oxymorphone.
16. Thebaine.
17. Dihydroetorphine.
18. Oripavine.
19. Noroxymorphone.

§ 9. Paragraph 4 of subdivision (b) of schedule II of section 3306 of the public health law, as amended by chapter 244 of the laws of 2016, is amended to read as follows:

(4) Coca leaves and any salt, compound, derivative, or preparation of coca leaves, and any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of these substances including cocaine and ecgonine, their salts, isomers, and salts of isomers, except that the substances shall not include: (A) decocainized coca leaves or extraction of coca leaves, which extractions do not contain cocaine or ecgonine; [or] (B) {123I} ioflupane; or (C) {18F}FP-CIT.

§ 10. Subdivision (c) of schedule II of section 3306 of the public health law is amended by adding a new paragraph 30 to read as follows:

(30) Oliceridine. (N-{(3-methoxythiophen-2-yl)methyl}({2-{(9R)-9-(pyridin-2-yl)-6-oxaspiro{4.5}decan-9-yl}ethyl})amine).

§ 11. Subdivision (f) of schedule II of section 3306 of the public health law, as amended by chapter 589 of the laws of 1996, the undesignated paragraph as amended by chapter 575 of the laws of 2001, is amended to read as follows:

(f) Hallucinogenic substances.

[Nabilone: Another name for nabilone: (+,-)-trans-3-(1,1-dimethylheptyl)-6, 6a, 7, 8, 10, 10a-hexahydro-1-hydroxy-6, 6-dimethyl-9H-dibenzo{b,d}pyran-9-one.] (1) Nabilone. Another name for nabilone: (+,-)-trans-3-(1,1-dimethylheptyl)-6,6a,7,8,10,10a-hexahydro-1-hydroxy-6,6-dimethyl-9H-dibenzo{b,d}pyran-9-one.

(2) Dronabinol {(-)-delta-9-transtetrahydrocannabinol} in an oral solution in a drug product approved for marketing by the United States Food and Drug Administration.

§ 12. Subparagraph (i) of paragraph 3 of subdivision (g) of schedule II of section 3306 of the public health law, as amended by section 2 of part BB of chapter 57 of the laws of 2023, is amended to read as follows:

(i) [4-anilino-N-phenenethylpiperidine] 4-anilino-N-phenethylpiperidine (ANPP)[.];

§ 13. Subdivision (h) of schedule II of section 3306 of the public health law, as amended by section 8 of part C of chapter 447 of the laws of 2012, is amended to read as follows:

(h) (1) Anabolic steroids. Unless specifically excepted or unless listed in another schedule, "anabolic steroid" shall mean any drug or hormonal substance, chemically and pharmacologically related to testosterone (other than estrogens, progestins, corticosteroids and dehydroepiandrosterone) and includes:

[(1) 3{beta}, 17-dihydroxy-5a-androstane] (i) 3{beta},17{beta}-dihydroxy-5{alpha}-androstane.

[(2) 3{alpha}, 17{beta}-dihydroxy-5a-androstane] (ii) 3{alpha},17{beta}-dihydroxy-5{alpha}-androstane.

[(3)] (iii) 5{alpha}-androstan-3,17-dione.

[(4)] (iv) 1-androstenediol (3{beta},17{beta}-dihydroxy-5{alpha}-androst-1-ene).

[(5)] (v) 1-androstenediol (3{alpha},17{beta}-dihydroxy-5{alpha}-androst-1-ene).

[(6)] (vi) 4-androstenediol [(3{beta}, 17{beta}-dihydroxy-androst-4-ene)] (3{beta},17{beta}-dihydroxy-androst-4-ene).

[(7)] (vii) 5-androstenediol [(3{beta},17{beta}-dihydroxy-androst-5-ene)] (3{beta},17{beta}-dihydroxy-androst-5-ene).

[(8)] (viii) 1-androstenedione [({5alpha}}-androst-1-en-3,17-dione)] (5{alpha}-androst-1-en-3,17-dione).

[(9)] (ix) 4-androstenedione (androst-4-en-3,17-dione).

[(10)] (x) 5-androstenedione (androst-5-en-3,17-dione).

[(11)] (xi) Bolasterone [(7{alpha},17{alpha}-dimethyl-17{beta}-hydroxyandrost-4-en-3-one)] (7{alpha},17{alpha}-dimethyl-17{beta}-hydroxyandrost-4-en-3-one).

[(12)] (xii) Boldenone [(17{beta}-hydroxyandrost-1, 4,-diene-3-one)] (17{beta}-hydroxyandrost-1,4-diene-3-one).

[(13)] (xiii) Boldione (androsta-1,4-diene-3,17-dione).

[(14)] (xiv) Calusterone [(7{beta},17{alpha}-dimethyl-17{beta}-hydroxyandrost-4-en-3-one)] (7{beta},17{alpha}-dimethyl-17{beta}-hydroxyandrost-4-en-3-one).

[(15)] (xv) Clostebol [(4-chloro-17{beta}-hydroxyandrost-4-en-3-one)] (4-chloro-17{beta}-hydroxyandrost-4-en-3-one).

[(16)] (xvi) Dehydrochloromethyltestosterone (4-chloro-17{beta}-hydroxy-17{alpha}-methyl-androst-1, 4-dien-3-one).

[(17) {Delta} 1-dihydrotestosterone] (xvii) {Delta}1-dihydrotestosterone (a.k.a. '1-testosterone') (17{beta}-hydroxy-5{alpha}-androst-1-en-3-one).

[(18)] (xviii) 4-dihydrotestosterone (17{beta}-hydroxy-androstan-3-one).

[(19)] (xix) Drostanolone (17{beta}-hydroxy-2{alpha}-methyl-5{alpha}-androstan-3-one).

[(20)] (xx) Ethylestrenol (17{alpha}-ethyl-17{beta}-hydroxyestr-4-ene).

[(21)] (xxi) Fluoxymesterone [(9-fluoro-17{alpha}-methyl-11{beta}, 17{beta}-dihydroxyandrost-4-en-3-one)] (9-fluoro-17{alpha}-methyl-11{beta},17{beta}-dihydroxyandrost-4-en-3-one).

[(22)] (xxii) Formebolone [(2-formyl-17{alpha}-methyl-11{alpha}, 17{beta}-dihydroxyandrost-1, 4-dien-3-one)] (2-formyl-17{alpha}-methyl-11{alpha},17{beta}-dihydroxyandrost-1,4-dien-3-one).

[(23)] (xxiii) Furazabol [(17{alpha}-methyl-17{beta}-hydroxyandrostano{2, 3-c}-furazan)] (17{alpha}-methyl-17{beta}-hydroxyandrostano{2,3-c}-furazan).

[(24) 13{beta}-ethyl-17{beta}-hyroxygon-4-en-3-one] (xxiv) 13{beta}-ethyl-17{beta}-hydroxygon-4-en-3-one.

[(25)] (xxv) 4-hydroxytestosterone [(4, 17{beta}-dihydroxy-androst-4-en-3-one)] (4,17{beta}-dihydroxy-androst-4-en-3-one).

[(26)] (xxvi) 4-hydroxy-19-nortestosterone [(4,17{beta}-dihydroxy-estr-4-en-3-one)] (4,17{beta}-dihydroxyestr-4-en-3-one).

[(27) desoxymethyltestosterone] (xxvii) Desoxymethyltestosterone (17{alpha}-methyl-5 {alpha}-androst-2-en-17{beta}-ol) (a.k.a., [madol)] 'madol').

[(28)] (xxviii) Mestanolone [(17{alpha}-methyl-17{beta}-hydroxy-5-androstan-3-one)] (17{alpha}-methyl-17{beta}-hydroxy-5-{alpha}-androstan- 3-one).

[(29)] (xxix) Mesterolone [(1{alpha}methyl-17{beta}-hydroxy-{5{alpha}}-androstan-3-one)] (1{alpha}-methyl-17{beta}-hydroxy-5{alpha}-androstan-3-one).

[(30)] (xxx) Methandienone [(17{alpha}-methyl-17{beta}-hydroxyandrost-1, 4-dien-3-one)] (17{alpha}-methyl-17{beta}-hydroxyandrost-1, 4-dien-3-one).

[(31)] (xxxi) Methandriol [(17{alpha}-methyl-3{beta}, 17{beta}-dihydroxyandrost-5-ene)] (17{alpha}-methyl-3{beta},17{beta}-dihydroxyandrost-5-ene).

[(32)] (xxxii) Methenolone [(1-methyl-17{beta}-hydroxy-5{alpha}-androst-1-en-3-one)] (1-methyl-17{beta}-hydroxy-5{alpha}-androst-1-en-3-one).

[(33) 17{alpha}-methyl-3{beta}, 17{beta}-dihydroxy-5-androstane] (xxxiii) 17{alpha}-methyl-3{beta},17{beta}-dihydroxy-5{alpha}-androstane.

[(34) 17{alpha}-methyl-3{alpha}, 17{beta}-dihydroxy-5a-androstane] (xxxiv) 17{alpha}-methyl-3{alpha},17{beta}-dihydroxy5{alpha}-androstane.

[(35) 17{alpha}-methyl-3{beta}, 17{beta}-dihydroxyandrost-4-ene.] (xxxv) 17{alpha}-methyl-3{beta},17{beta}-dihydroxyandrost-4-ene.

[(36) 17{alpha}-methyl-4-hydroxynandrolone (17{alpha}-methyl-4-hydroxy-17{beta}-hydroxyestr-4-en-3-one).] (xxxvi) 17{alpha}-methyl-4-hydroxynandrolone(17{alpha}-methyl-4-hydroxy-17{beta}-hydroxyestr-4-en-3-one).

[(37)] (xxxvii) Methyldienolone [(17{alpha}-methyl-17{beta}-hydroxyestra-4,9(10)-dien-3-one).] (17{alpha}-methyl-17{beta}-hydroxyestra-4,9(10)-dien-3-one).

[(38)] (xxxviii) Methyltrienolone [(17{alpha}-methyl-17{beta}-hydroxyestra-4, 9-11-trien-3-one).] (17{alpha}-methyl-17{beta}-hydroxyestra-4,9,11-trien-3-one).

[(39)] (xxxix) Methyltestosterone (17{alpha}-methyl-17{beta}-hydroxyandrost-4-en-3-one).

[(40)] (xl) Mibolerone (7{alpha},17{alpha}-dimethyl-17{beta}-hydroxyestr-4-en-3-one).

[(41) 17{alpha}-methyl-{Delta} 1-dihydrotestosterone(17b{beta}-hydroxy-17{alpha}-methyl-5{alpha}-androst-1-en-3-one)] (xli) 17{alpha}-methyl-{Delta}1-dihydrotestosterone(17{beta}-hydroxy-17{alpha}-methyl-5{alpha}-androst-1-en-3-one) (a.k.a. '17-{alpha}-methyl-1-testosterone').

[(42) Nandrolone(17{beta}-hydroxyestr-4-en-3-one).] (xlii) Nandrolone (17{beta}-hydroxyestr-4-en-3-one).

[(43)] (xliii) 19-nor-4-androstenediol [(3{beta},17{beta}-dihydroxyestr -4-ene).] (3{beta},17{beta}-dihydroxyestr-4-ene).

[(44)] (xliv) 19-nor-4-androstenediol [(3{alpha},17{beta}-dihydroxyestr-4-ene).] (3{alpha},17{beta}-dihydroxyestr-4-ene).

[(45)] (xlv) 19-nor-5-androstenediol [(3{beta},17{beta}-dihydroxyestr-5-ene).] (3{beta},17{beta}-dihydroxyestr-5-ene).

[(46)] (xlvi) 19-nor-5-androstenediol [(3{alpha},17{beta}-dihydroxyestr-5-ene).] (3{alpha},17{beta}-dihydroxyestr-5-ene).

[(47) 19-nor-4,9(10)-androstadienedione (estra-4,9(10)-diene-3,17-dione).] (xlvii) 19-nor-4,9 (10)-androstadienedione (estra-4,9(10)-diene-3,17-dione).

[(48)] (xlviii) 19-nor-4-androstenedione (estr-4-en-3,17-dione).

[(49)] (xlix) 19-nor-5-androstenedione (estr-5-en-3,17-dione).

[(50)] (l) Norbolethone [(13{beta}, 17{alpha}-diethyl-17{beta}-hydroxygon-4-en-3-one).] (13{beta},17{alpha}-diethyl-17{beta}-hydroxygon-4-en-3-one).

[(51)] (li) Norclostebol [(4-chloro-17{beta}-hydroxyestr-4-en-3-one).] (4-chloro-17{beta}-hydroxyestr-4-en-3-one).

[(52)] (lii) Norethandrolone (17{alpha}-ethyl-17{beta}-hydroxyestr-4-en-3-one).

[(53)] (liii) Normethandrolone [(17{alpha}-methyl-17{beta}-hydroxestr-4-en-3-one).] (17{alpha}-methyl-17{beta}-hydroxyestr-4-en-3-one).

[(54)] (liv) Oxandrolone [(17{alpha}-methyl-17{beta}-hydroxy-2-oxa-{5{alpha}}-androstan-3-one).] (17{alpha}-methyl-17{beta}-hydroxy-2-oxa-5{alpha}-androstan-3-one).

[(55)] (lv) Oxymesterone [(17{alpha}-methyl-4, 17{beta}-dihydroxy androst-4-en-3-one).] (17{alpha}-methyl-4,17{beta}-dihydroxyandrost-4-en-3-one).

[(56)] (lvi) Oxymetholone [(17 {alpha}-methyl-2-hydroxymethylene-17 {beta}-hydroxy-{5{alpha}}- androstan-3-one).] (17{alpha}-methyl-2-hydroxymethylene-17{beta}-hydroxy-5{alpha}-androstan-3-one).

[(57)] (lvii) Stanozolol [(17{alpha}-methyl-17{beta}-hydroxy-{5{alpha}}-androst-2-eno{3,2-c}-pyrazole).] (17{alpha}-methyl-17{beta}-hydroxy-5{alpha}-androst-2-eno{3,2-c}-pyrazole).

[(58)] (lviii) Stenbolone [(17{beta}-hydroxy-2-methyl-{5{alpha}}-androst-1-en-3-one).] (17{beta}-hydroxy-2-methyl-5{alpha}-androst-1-en-3-one).

[(59)] (lix) Testolactone [(13-hydroxy-3-oxo-13, 17-secoandrosta-1, 4-dien-17-oic acid lactone).] (13-hydroxy-3-oxo-13,17-secoandrosta1,4-dien-17-oic acid lactone).

[(60)] (lx) Testosterone (17{beta}-hydroxyandrost-4-en-3-one).

[(61)] (lxi) Tetrahydrogestrinone [(13{beta}, 17{alpha}-diethyl-17{beta}-hydroxygon-4, 9, 11-trien-3-one).] (13{beta},17{alpha}-diethyl-17{beta}-hydroxygon-4,9,11-trien-3-one).

[(62)] (lxii) Trenbolone [(17{beta}-hydroxyestr-4, 9, 11-trien-3-one).] (17{beta}-hydroxyestr-4,9,11-trien-3-one).

[(63)] (lxiii) 5{alpha}-androstan-3,6,17-trione.

(lxiv) 6-bromo-androsta-1,4-diene-3,17-dione.

(lxv) 6-bromo-androstan-3,17-dione.

(lxvi) 4-chloro-17{alpha}-methyl-androsta-1,4-diene-3,17{beta}-diol.

(lxvii) 4-chloro-17{alpha}-methyl-androst-4-ene-3{beta},17{beta}-diol.

(lxviii) 4-chloro-17{alpha}-methyl-17{beta}hydroxy-androst-4-en-3-one.

(lxix) 4-chloro-17{alpha}-methyl-17{beta}hydroxy-androst-4-ene-3,11-dione.

(lxx) 2{alpha},17{alpha}-dimethyl-17{beta}-hydroxy-5{beta}-androstan-3-one.

(lxxi) 2{alpha},3{alpha}-epithio-17{alpha}-methyl-5{alpha}androstan-17{beta}-ol.

(lxxii) estra-4,9,11-triene-3,17-dione.

(lxxiii) {3,2-c}furazan-5{alpha}-androstan-17{beta}-ol.

(lxxiv) 18a-homo-3-hydroxy-estra-2,5(10)-dien-17-one.

(lxxv) 4-hydroxy-androst-4-ene-3,17-dione.

(lxxvi) 17{beta}-hydroxy-androstano{2,3-d}isoxazole.

(lxxvii) 17{beta}-hydroxy-androstano{3,2-c}isoxazole.

(lxxviii) 3{beta}-hydroxy-estra-4,9,11-trien-17-one.

(lxxix) Methasterone (2{alpha},17{alpha}-dimethyl-5{alpha}-androstan-17{beta}-ol-3-one or 2{alpha},17{alpha}-dimethyl-17{beta}-hydroxy-5{alpha}-androstan-3-one).

(lxxx) 17{alpha}-methyl-androsta-1,4-diene-3,17{beta}-diol.

(lxxxi) 17{alpha}-methyl-5{alpha}-androstan-17{beta}-ol.

(lxxxii) 17{alpha}-methyl-androstan-3-hydroxyimine-17{beta}-ol.

(lxxxiii) 6{alpha}-methyl-androst-4-ene-3,17-dione.

(lxxxiv) 17{alpha}-methyl-androst-2-ene-3,17{beta}diol.

(lxxxv) Prostanozol (17{beta}-hydroxy-5{alpha}-androstano{3,2-c}pyrazole) or {3,2-c}pyrazole-5{alpha}-androstan-17{beta}-ol.

(lxxxvi) {3,2-c}pyrazole-androst-4-en-17{beta}-ol.

(lxxxvii) Any salt, ester or ether of a drug or substance described or listed in this subdivision.

(2) (i) Subject to subparagraph (ii) of this paragraph, a drug or hormonal substance, other than estrogens, progestins, corticosteroids, and dehydroepiandrosterone, that is not listed in paragraph one of this subdivision and is derived from, or has a chemical structure substantially similar to, one or more anabolic steroids listed in paragraph one of this subdivision shall be considered to be an anabolic steroid for purposes of this schedule if:

(A) the drug or substance has been created or manufactured with the intent of producing a drug or other substance that either:

1. promotes muscle growth; or

2. otherwise causes a pharmacological effect similar to that of testosterone; or

(B) the drug or substance has been, or is intended to be, marketed or otherwise promoted in any manner suggesting that consuming it will promote muscle growth or any other pharmacological effect similar to that of testosterone.

(ii) A substance shall not be considered to be a drug or hormonal substance for purposes of this subdivision if:

(A) it is:

1. an herb or other botanical;

2. a concentrate, metabolite, or extract of, or a constituent isolated directly from, an herb or other botanical; or

3. a combination of two or more substances described in clause one or two of this item;

(B) it is a dietary ingredient for purposes of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.); and

(C) it is not anabolic or androgenic.

(iii) In accordance with subdivision one of section thirty-three hundred ninety-six of this article, any person claiming the benefit of an exemption or exception under subparagraph (ii) of this paragraph shall bear the burden of going forward with the evidence with respect to such exemption or exception.

§ 14. Subdivision (c) of schedule III of section 3306 of the public health law is amended by adding a new paragraph 15 to read as follows:

(15) Perampanel, its salts, isomers and salts of isomers.

§ 15. Subdivision (c) of schedule IV of section 3306 of the public health law is amended by adding seven new paragraphs 54, 55, 56, 57, 58, 59 and 60 to read as follows:

(54) Alfaxalone.

(55) Brexanolone.

(56) Daridorexant.

(57) Lemborexant.

(58) Remimazolam.

(59) Suvorexant.

(60) Zuranolone.

§ 16. Paragraph 10 of subdivision (e) of schedule IV of section 3306 of the public health law, as amended by chapter 589 of the laws of 1996, is amended and two new paragraphs 13 and 14 are added to read as follows:

(10) SPA((-)[)]-1-dimethylamino-1, 2-diphenylethane).

(13) Serdexmethylphenidate.

(14) Solriamfetol (2-amino-3-phenylpropyl carbamate; benzenepropanol, beta-amino-, carbamate(ester)).

§ 17. Subdivision (f) of schedule IV of section 3306 of the public health law, as added by chapter 664 of the laws of 1985, paragraph 2 as added by chapter 457 of the laws of 2006 and paragraph 3 as added by section 14 of part C of chapter 447 of the laws of 2012, is amended to read as follows:

(f) Other substances. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture or preparation which contains any quantity of the following substances, including its salts, isomers, and salts of such isomers, whenever the existence of such salts, isomers, and salts of isomers is possible:

(1) Pentazocine.

(2) Butorphanol (including its optical isomers).

(3) Tramadol in any quantities.

(4) Eluxadoline (5-{{{(2S))-2-amino-3-{4-(aminocarbonyl)-2,6-dimethylphenyl}-1-oxopropyl}{(1S)-1-(4-phenyl-1H-imidazol-2-yl)ethyl}amino}methyl}-2-methoxybenzoic acid) (including its optical isomers) and its salts, isomers, and salts of isomers.

(5) Lorcaserin.

§ 18. Subdivision (d) of schedule V of section 3306 of the public health law, as amended by section 16 of part C of chapter 447 of the laws of 2012, is amended to read as follows:

(d) Depressants. Unless specifically exempted or excluded or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers, and salts of isomers:

(1) Ezogabine [{N-{2-amino-4-(4-fluorobenzylamino)-phenyl}-carbamic acid ethyl ester}] (N-{2-amino-4-(4-fluorobenzylamino)-phenyl}-carbamic acid ethyl ester).

(2) Lacosamide [{(R)-2-acetoamido-N-benzyl-3-methoxy-propionamide}] ((R)-2-acetoamido-N-benzyl-3-methoxy-propionamide).

(3) Pregabalin [{(S)-3-(aminomethyl)-5-methylhexanoic acid}] ((S)-3-(aminomethyl)-5-methylhexonoic acid).

(4) Brivaracetam ((2S)-2-{(4R)-2-oxo-4-propylpyrrolidin-1-yl}butanamide). Some trade or other names: BRV; UCB-34714; Briviact.

(5) Cenobamate ({(1R)-1-(2-chlorophenyl)-2-(tetrazol-2-yl)ethyl} carbamate; 2H-tetrazole-2-ethanol, alpha-(2-chlorophenyl)-, carbamate (ester), (alphaR)-; carbamic acid(R)-(+)-1-(2-chlorophenyl)-2-(2H-tetrazol-2-yl)ethyl ester).

(6) Ganaxolone (3{alpha}-hydroxy-3{beta}-methyl-5{alpha}-pregnan-20-one).

(7) Lasmiditan (2,4,6-trifluoro-N-(6-(1-methylpiperidine-4-carbonyl) pyridine-2-yl-benzamide).

§ 19. Subdivision 2 of section 3342 of the public health law, as amended by chapter 466 of the laws of 2024, is amended to read as follows:

2. An institutional dispenser may dispense controlled substances for use off its premises only pursuant to a prescription, prepared and filed in conformity with this title, provided, however, that, in an emergency situation as defined by rule or regulation of the department, a practitioner in a hospital without a full-time pharmacy may dispense controlled substances to a patient in a hospital emergency room for use off the premises of the institutional dispenser for a period not to exceed twenty-four hours, [unless the federal drug enforcement administration has authorized a longer time period for the purpose of initiating maintenance treatment, detoxification treatment, or both] and

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

§ 20. Subdivision 1 of section 3302 of the public health law, as amended by chapter 92 of the laws of 2021, is amended to read as follows:

1. ["Addict"] "Person with a substance use disorder" means a person who habitually uses a controlled substance for a non-legitimate or unlawful use, and who by reason of such use is dependent thereon.

§ 21. Subdivision 1 of section 3331 of the public health law, as added by chapter 878 of the laws of 1972, is amended to read as follows:

1. Except as provided in titles III or V of this article, no substance in schedules II, III, IV, or V may be prescribed for or dispensed or administered to [an addict] a person with a substance use disorder or habitual user.

§ 22. The title heading of title 5 of article 33 of the public health law, as added by chapter 878 of the laws of 1972, is amended to read as follows:

DISPENSING TO [ADDICTS]
PERSONS WITH A SUBSTANCE USE DISORDER
AND HABITUAL USERS

§ 23. Section 3350 of the public health law, as added by chapter 878 of the laws of 1972, is amended to read as follows:

§ 3350. Dispensing prohibition. Controlled substances may not be prescribed for, or administered or dispensed to [addicts] persons with a substance use disorder or habitual users of controlled substances, except as provided by this title or title III of this article.

§ 24. Section 3351 of the public health law, as added by chapter 878 of the laws of 1972 and subdivision 5 as amended by chapter 558 of the laws of 1999, is amended to read as follows:

§ 3351. Dispensing for medical use. 1. Controlled substances may be prescribed for, or administered or dispensed to [an addict] a person with a substance use disorder or habitual user:

(a) during emergency medical treatment unrelated to [abuse] such substance use disorder or habitual use of controlled substances;

(b) who is a bona fide patient suffering from an incurable and fatal disease such as cancer or advanced tuberculosis;

(c) who is aged, infirm, or suffering from serious injury or illness and the withdrawal from controlled substances would endanger the life or impede or inhibit the recovery of such person.

1-a. A practitioner may prescribe, administer and dispense any schedule III, IV, or V narcotic drug approved by the federal food and drug administration specifically for use in maintenance or detoxification treatment to a person with a substance use disorder or habitual user.

2. Controlled substances may be ordered for use by [an addict] a person with a substance use disorder or habitual user by a practitioner and administered by a practitioner [or], registered nurse, emergency medical technician-paramedic, acting within their scope of practice, to relieve acute withdrawal symptoms.

3. Methadone, or such other controlled substance designated by the commissioner as appropriate for such use, may be ordered for use [of an addict] by a person with a substance use disorder by a practitioner and dispensed or administered by a practitioner or [his] their designated

agent as interim treatment for [an addict on a waiting list for admission to an authorized maintenance program] a person with a substance use disorder while arrangements are being made for referral to treatment for such substance use disorder.

4. Methadone, or such other controlled substance designated by the commissioner as appropriate for such use, may be administered to [an addict] a person with a substance use disorder by a practitioner or by [his] their designated agent acting under the direction and supervision of a practitioner, as part of a [regime] regimen designed and intended as maintenance or detoxification treatment or to withdraw a patient from addiction to controlled substances.

5. [Methadone] Notwithstanding any other law and consistent with federal requirements, methadone, or such other controlled substance designated by the commissioner as appropriate for such use, may be administered or dispensed directly to [an addict] a person with a substance use disorder by a practitioner or by [his] their designated agent acting under the direction and supervision of a practitioner, as part of a substance [abuse or chemical dependence] use disorder program approved pursuant to article [twenty-three or] thirty-two of the mental hygiene law.

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

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

§ 26. This act shall take effect immediately; provided, however, that the amendments to subdivision 2 of section 3342 of the public health law made by section nineteen of this act, shall take effect on the same date and in the same manner as chapter 466 of the laws of 2024, takes effect.

PART P

Section 1. Section 2805-b of the public health law is amended by adding a new subdivision 6 to read as follows:

6. When emergency services are provided as an organized service of a general hospital licensed pursuant to this article, the hospital must terminate the pregnancy of any individual presenting for care at the hospital if the individual has an emergency medical condition, and termination of the pregnancy is needed to stabilize that individual, unless the individual (or the individual's legally authorized representative, when the legally authorized representative is authorized to act on behalf of the individual) does not consent to the treatment. If such consent is not provided, a general hospital meets the requirements of this subdivision with respect to an individual if the hospital offers the individual the treatment. Hospitals that have limited capability for receiving and treating high risk maternity patients in need of special-

ized emergency care shall develop and implement standard descriptions of such patients and have triage, treatment, and transfer protocols. Such protocols shall provide that patients shall be transferred to another hospital only when:

(a) the patient's condition is stable or being managed;

(b) the attending practitioner has authorized the transfer; and

(c) the receiving hospital is informed, can provide the necessary resources to care for the patient, and has accepted the patient.

§ 2. Section 2599-bb of the public health law is amended by adding a new subdivision 1-a to read as follows:

1-a. At a health care prescriber's request, the prescription label for abortion medications, including, but not limited to, mifepristone and misoprostol shall include the prescribing health care facility name or address instead of the name of the practitioner. The prescriber shall inform the patient whether the prescriber has requested to include the health care facility name or address on the prescription label.

§ 3. Subdivision 1 of section 6810 of the education law, as amended by section 2 of part V of chapter 57 of the laws of 2012, is amended and a new subdivision 10-b is added to read as follows:

1. No drug for which a prescription is required by the provisions of the Federal Food, Drug and Cosmetic Act or by the commissioner of health shall be distributed or dispensed to any person except upon a prescription written by a person legally authorized to issue such prescription. Such drug shall be compounded or dispensed by a licensed pharmacist, and no such drug shall be dispensed without affixing to the immediate container in which the drug is sold or dispensed a label bearing the name and address of the owner of the establishment in which it was dispensed, the date compounded, the number of the prescription under which it is recorded in the pharmacist's prescription files, the name of the prescriber, or the name or address of the prescribing health care facility pursuant to section twenty-five hundred ninety-nine-bb of the public health law, the name and address of the patient, and the directions for the use of the drug by the patient as given upon the prescription. All labels shall conform to such rules and regulations as promulgated by the commissioner pursuant to section sixty-eight hundred twenty-nine of this article. The prescribing and dispensing of a drug which is a controlled substance shall be subject to additional requirements provided in article thirty-three of the public health law. The words "drug" and "prescription required drug" within the meaning of this article shall not be construed to include soft or hard contact lenses, eyeglasses, or any other device for the aid or correction of vision. Nothing in this subdivision shall prevent a pharmacy from furnishing a drug to another pharmacy which does not have such drug in stock for the purpose of filling a prescription.

10-b. At the request of a practitioner pursuant to section twenty-five hundred ninety-nine-bb of the public health law, a pharmacy that receives an electronic prescription shall list the prescribing health care facility name or address on the prescription label instead of the name of the practitioner.

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

PART Q

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

(nn) (i) Medical assistance shall include the coverage of the following services for individuals with iatrogenic infertility directly or indirectly caused by medical treatment, which is an impairment of fertility resulting from surgery, radiation, chemotherapy, sickle cell treatment, or other medical treatment affecting reproductive organs or processes:

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

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

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

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

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

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

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

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

§ 4. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2025; provided, however, that section one of this act shall take effect October 1, 2025. Effective immediately, the addition, amendment and/or repeal of any rule

or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such date.

PART R

Section 1. Section 3001 of the public health law is amended by adding three new subdivisions 22, 23 and 24 to read as follows:

22. "Emergency medical services agencies" shall mean organized entities certified or licensed by the department to provide emergency medical service, including ambulance services, advanced life support first response services, and other integrated first response services responsible for providing emergency medical services.

23. "Communities" shall include counties, cities, towns, villages, and special districts within New York state.

24. "Scoring matrix" shall refer to the emergency medical community assessment program framework of criteria and weightings established by the department for evaluating emergency medical services systems and agencies.

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

4-a. In determining public need for additional emergency medical services, the regional emergency medical services councils shall consider factors related to access, community need, consistency with state emergency medical system plans, and the feasibility and impact of the proposed service, including any innovations or improvements in service delivery, and other factors as determined by the commissioner.

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

§ 3019. Emergency medical community assessment program. 1. The emergency medical community assessment program is hereby established to evaluate and enhance the emergency medical services throughout the state. The program shall assess the capabilities and performance of emergency medical services agencies and the service they provide to the communities they serve, assigning scores to identify strengths, deficiencies, and areas for improvement.

2. The department, in consultation with the state council and other stakeholders, shall establish the criteria and scoring matrix to evaluate emergency medical services systems. Criteria shall include, but not be limited to, system organization, access to care, response effectiveness, operational efficiency, and quality improvement. The scoring matrix shall ensure objective evaluations and consistency statewide, with assessments informing resource allocation and system improvements. Assessment results shall be publicly accessible and integrated into county emergency medical services plans to identify gaps, prioritize resources, and enhance system readiness and sustainability.

3. The department shall prepare and publish, in a manner determined by the department, a comprehensive statewide report of the emergency medical community assessment program results at least every five years, or at such intervals as deemed necessary by the commissioner.

4. All jurisdictions and emergency medical services agencies, except cities with populations of one million or more, shall participate in the program and provide timely and accurate information.

5. The commissioner is authorized to allocate funding to assist counties and agencies in implementing the program, conducting assessments, addressing deficiencies, and improving system performance and shall

prioritize areas with significant resource gaps and align with program objectives.

§ 4. The public health law is amended by adding a new section 3019-a to read as follows:

§ 3019-a. Statewide comprehensive emergency medical system plan. 1. The state emergency medical services council, in collaboration and with final approval of the department, shall develop and maintain a statewide comprehensive emergency medical system plan that shall provide for a coordinated emergency medical system within the state, which shall include but not be limited to:

(a) establishing a comprehensive statewide emergency medical system, consisting of facilities, transportation, workforce, communications, and other components to improve the delivery, access and utilization of emergency medical services and thereby decrease morbidity, hospitalization, disability, and mortality;

(b) improving the accessibility of high-quality emergency medical services;

(c) coordinating professional medical organizations, hospitals, and other public and private agencies in developing alternative delivery models for persons who are presently using emergency departments for routine, nonurgent and primary medical care to be served appropriately and economically; provided, however, that the provisions of this subdivision shall not be mandated for cities with a population of one million or more; and

(d) developing, conducting, promoting, and encouraging programs of initial and advanced education and training designed to enhance and recognize the knowledge and skills of emergency medical services practitioners throughout the state with emphasis on regions underserved by or with limited access to emergency medical services.

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

3. Each county shall develop and maintain a comprehensive county emergency medical system plan, in a manner and format established by the department, that shall provide for a coordinated emergency medical system within the county to provide essential emergency medical services for all residents within the county. The county office of emergency medical services shall be responsible for the development, implementation, and maintenance of the comprehensive county emergency medical system plan.

(a) County plans shall require review and approval by the department. The state emergency medical services council and the regional emergency medical services council may review county plans and provide recommendations to the department prior to final approval.

(b) Any permanent modifications to the approved county emergency medical system plan, including the dissolution of an ambulance service district or other significant modification of emergency medical services agency coverage, including but not limited to an agency choosing to stop servicing an area that is not otherwise served by an agency, shall require review and approval by the department prior to implementation. Such modifications shall be submitted in writing to the department no less than one hundred eighty days before the proposed effective date of the county plans.

(c) The county plan shall designate a primary responding emergency medical services agency or agencies responsible for responding to requests for emergency medical services within each part of the county. No emergency medical services agency designated in the county plan, may refuse to respond to a request for service within their primary response area or as listed in the plan unless they can prove, to the satisfaction of the department, that they are unable to respond because of capacity limitations.

(d) The county plan shall incorporate all ambulance services that hold a valid ambulance service certificate and have any designated geographic area within the county listed as primary territory on the operating certificate issued by the department.

(e) No county shall remove or reassign an area served by an existing emergency medical services agency where such emergency medical services agency is compliant with all statutory and regulatory requirements, and has agreed to participate in the provision of the approved county plan.

(f) The county plan shall incorporate findings from the emergency medical community assessment program, as described in section three thousand nineteen of this article, to identify opportunities for improvement, prioritize resource allocation, and determine additional needs for emergency medical services within the county.

(g) The county plan shall include any findings which demonstrate a public need for additional emergency medical services based on the considerations outlined in section three thousand eight of this article. Such findings shall be submitted to the regional emergency medical services council and the state emergency medical services council to provide recommendations and inform decisions related to regional determinations of public need.

§ 5. The opening paragraph of subdivision 1 of section 122-b of the general municipal law, as amended by chapter 471 of the laws of 2011, is amended and a new paragraph (g) is added to read as follows:

[Any] General ambulance services are an essential service and a matter of state concern. Every county, city, town [or] and village, acting individually or jointly or in conjunction with a special district, [may provide] shall ensure that an emergency medical service, a general ambulance service or a combination of such services are provided for the purpose of providing prehospital emergency medical treatment or transporting sick or injured persons found within the boundaries of the municipality or the municipalities acting jointly to a hospital, clinic, sanatorium or other place for treatment of such illness or injury, [and for] provided, however, the provisions of this subdivision shall not apply to a city with a population of one million or more. For purposes of this section, "special district" shall have the same meaning as "improvement districts" as defined in article twelve-a of the town law. In furtherance of that purpose, a county, city, town or village may:

(g) Establish a special district for the financing and operation of general ambulance services, including support for agencies currently providing emergency medical services, as set forth by this section, whereby any county, city, town or village, acting individually, or jointly with any other county, city, town and/or village, through its governing body or bodies, following applicable procedures as are required for the establishment of fire districts in article eleven of the town law or following applicable procedures as are required for the establishment of joint fire districts in article eleven-A of the town law, with such special district being authorized by this section to be established in all or any part of any such participating county or coun-

ties, town or towns, city or cities and/or village or villages; provided that the term "town board", "town", or "commissioner", insofar as either is used in article eleven or article eleven-A of the town law, shall mean the legislative body of a village, city having a population less than one million, and county outside of any such city, as applicable for such village, city, and county to establish or extend a special district or special improvement district as authorized under this section. Notwithstanding any provision of this article, rule or regulation to the contrary, any special district created under this section shall not overlap with a pre-existing city, town or village ambulance district unless such existing district is merged into the newly created district. No city, town or village shall eliminate or dissolve a pre-existing ambulance district without express approval and consent by the county to assume responsibility for the emergency medical services previously provided by such district. Such express county approval and consent shall be adopted by resolution of the county legislative body, and the resolution shall be filed with the Department of State. When a special district is established pursuant to this article, the cities, towns, or villages contained within the county shall not reduce current ambulance funding without such changes being incorporated into the comprehensive county emergency medical system plan.

§ 6. Section 3000 of the public health law, as amended by chapter 804 of the laws of 1992, is amended to read as follows:

§ 3000. Declaration of policy and statement of purpose. The furnishing of medical assistance in an emergency is a matter of vital state concern affecting the public health, safety and welfare. Emergency medical services and ambulance services are essential services and shall be available to every person in the state in a reliable manner. Prehospital emergency medical care, other emergency medical services, the provision of prompt and effective communication among ambulances and hospitals and safe and effective care and transportation of the sick and injured are essential public health services and shall be available to every person in the state in a reliable manner.

It is the purpose of this article to promote the public health, safety and welfare by providing for certification of all advanced life support first response services and ambulance services; the creation of regional emergency medical services councils; and a New York state emergency medical services council to develop minimum training standards for certified first responders, emergency medical technicians and advanced emergency medical technicians and minimum equipment and communication standards for advanced life support first response services and ambulance services.

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

1. "Emergency medical service" means [initial emergency medical assistance including, but not limited to, the treatment of trauma, burns, respiratory, circulatory and obstetrical emergencies.] a coordinated system of medical response, including assessment, treatment, transportation, emergency medical dispatch, medical direction, and emergency medical services education that provides essential emergency and non-emergency care and transportation for the ill and injured, while supporting public health, emergency preparedness, and risk mitigation through an organized and planned response system.

§ 8. The public health law is amended by adding a new section 3003-c to read as follows:

§ 3003-c. Emergency medical services demonstration programs. 1. The purpose of this section is to promote innovation in emergency medical services by enabling agencies and practitioners to develop and test novel delivery models and care strategies that address the diverse needs of their communities. This includes improving patient outcomes, system efficiency, and cost-effectiveness, particularly in rural and underserved regions. Demonstration programs may enhance the operational goals of state and county emergency medical services plans and serve as models for broader adoption statewide.

2. The commissioner is authorized to:

(a) approve emergency medical services demonstration programs that align with the objectives of this section, ensuring that they address regional needs and promote system-level improvements;

(b) provide financial support for these programs, subject to the availability of appropriated funds; and

(c) grant narrowly tailored waivers for specific provisions of this article, article thirty-A of this chapter, or applicable regulations, as necessary to implement approved demonstration programs. Waivers shall prioritize patient safety and the integrity of care delivery.

3. Emergency medical services demonstration programs shall be submitted to the department for review and approval prior to implementation. Proposals must include a detailed plan outlining program objectives, operational details, anticipated outcomes, and mechanisms to ensure patient safety and compliance with applicable laws and regulations. Approved demonstration programs shall undergo periodic evaluation, assessing metrics such as patient outcomes, system performance, and cost-effectiveness, to ensure alignment with program goals and inform potential statewide adoption.

4. Demonstration programs approved under this section shall not include, overlap, or replicate services included in the community-based paramedicine demonstration program as defined under section three thousand eighteen of this article.

§ 9. Section 3020 of the public health law is amended by adding a new subdivision 3 to read as follows:

3. The department, in consultation with the state council, shall establish standards for the licensure of emergency medical services practitioners by the commissioner. Such standards shall align with existing requirements for certification and shall not impose additional burdens or requirements beyond those necessary to ensure competence and public safety. The term "licensed" shall replace "certified" to reflect the professional status of emergency medical services practitioners, including but not limited to emergency medical technicians and advanced emergency medical technicians.

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

PART S

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

§ 4552. Notice of material transactions; requirements. 1. A health care entity shall submit to the department written notice, with supporting documentation as described below and further defined in regulation developed by the department, which the department shall be in receipt of at least [thirty] sixty days before the closing date of the transaction,

in the form and manner prescribed by the department. Immediately upon the submission to the department, the department shall submit electronic copies of such notice with supporting documentation to the antitrust, health care and charities bureaus of the office of the New York attorney general. Such written notice shall include, but not be limited to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Annually, for a five-year period following closing of the transaction and on the date of such anniversary, parties to a material transaction shall notify the department, in the form and manner prescribed by the department, of factors and metrics to assess the impacts of the transaction on cost, quality, access, health equity, and competition.

The department may require that any party to a transaction, including any parents or subsidiaries thereof, submit additional documents and information in connection with the annual report required under this paragraph, to the extent such additional information is necessary to assess the impacts of the transaction on cost, quality, access, health equity, and competition or to verify or clarify information submitted in support or as part of the annual report required under this paragraph. Parties shall submit such information within twenty-one days of request.

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

(b) In the event the department determines that a full cost and market impact review is required, the department shall have discretion to require parties to delay the proposed transaction closing until such cost and market impact review is completed, but in no event shall the closing be delayed more than one hundred eighty days from the date the department completes its preliminary review of the proposed transaction.

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

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

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

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

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

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

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

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

PART T

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

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

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

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

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

(ii) have successfully completed a didactic and clinical training course and post course preceptorship as appropriate to scope of practice that aligns with guidance released by the commissioner.

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

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

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

(a) Notwithstanding any other provision of law, rule, or regulation to the contrary, when any New York state accredited hospital, accredited sexual assault examiner program, or licensed health care provider furnishes services to any sexual assault survivor, including but not limited to a health care forensic examination in accordance with the sex offense evidence collection protocol and standards established by the department of health, such hospital, sexual assault examiner program, or licensed healthcare provider shall provide such services to the person without charge and shall bill the office directly. The office, in consultation with the department of health, shall define the specific services to be covered by the sexual assault forensic exam reimbursement fee, which must include at a minimum forensic examiner services, hospital or healthcare facility services related to the exam, and any necessary related laboratory tests or pharmaceuticals; including but not limited to HIV post-exposure prophylaxis provided by a hospital emergency room at the time of the forensic rape examination pursuant to para-

graph [(c)] (f) of subdivision one of section twenty-eight hundred five-i of the public health law. For a person eighteen years of age or older, follow-up HIV post-exposure prophylaxis costs shall continue to be reimbursed according to established office procedure. The office, in consultation with the department of health, shall also generate the necessary regulations and forms for the direct reimbursement procedure.

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

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

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

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

PART U

Section 1. Paragraph (g) of subdivision 2 of section 4100 of the public health law is REPEALED.

§ 2. Paragraphs (h) and (i) of subdivision 2 of section 4100 of the public health law, paragraph (h) as added by chapter 545 of the laws of 1965 and paragraph (i) as added by chapter 690 of the laws of 1994, are amended to read as follows:

[(h)] (g) prescribe and prepare the necessary methods and forms for obtaining and preserving records and statistics of autopsies which are conducted by a coroner or by a medical examiner, or by [his] their order, within the state of New York, and shall require all those performing such autopsies, for the purpose of determining the cause of death or the means or manner of death, to enter upon such record the pathological appearances and findings embodying such information as may be prescribed, and to append thereto the diagnosis of the cause of death and the means or manner of death[.]; and

[(i)] (h) upon notification by the division of criminal justice services that a person who was born in the state is a missing child, flag the certificate record of that person in such manner that whenever a copy of the record is requested, [he or she] such person shall be alerted to the fact that the record is that of a missing child. The commissioner shall also notify the appropriate registrar to likewise flag [his or her] their records. The commissioner or registrar shall immediately report to the local law enforcement authority and the division of criminal justice services any request concerning flagged birth records or knowledge as to the whereabouts of any missing child. Upon notification by the division of criminal justice services that the missing child has been recovered, the commissioner shall remove the flag from the person's certificate record and shall notify any other previously notified registrar to remove the flag from [his or her] their record. In the city of New York, the commissioner of the department of health for the city of New York shall implement the requirements of this paragraph.

§ 3. Section 4104 of the public health law, as amended by chapter 491 of the laws of 2019, is amended to read as follows:

§ 4104. Vital statistics; application of article. The provisions of this article except for the provisions contained in paragraph [(i)] (h) of subdivision two and subdivision four of section four thousand one hundred, section four thousand one hundred three, subdivision two of section four thousand one hundred thirty-five, section four thousand one hundred thirty-five-b, subdivision eight of section four thousand one hundred seventy-four, paragraphs (b) and (e) of subdivision one, paragraph (a) and (b) of subdivision three, and subdivisions five and eight of section four thousand one hundred thirty-eight, subdivision eleven of section four thousand one hundred thirty-eight-c, paragraph (b) of subdivision three of section four thousand one hundred thirty-eight-d, section four thousand one hundred thirty-eight-e and section four thousand one hundred seventy-nine of this article, shall not apply to the city of New York.

§ 4. Subdivision (h) of section 4170 of the public health law, as added by chapter 690 of the laws of 1994, is amended to read as follows:

(h) immediately notify the division of criminal justice services in the event that a copy of a birth certificate or information concerning the birth records of any person whose record is flagged pursuant to paragraph [(i)] (h) of subdivision two of section four thousand one hundred of this article is requested. In the event that a copy of the birth certificate of a person whose record is so flagged is requested in person, the registrar's personnel accepting the request shall immediately notify [his or her] their supervisor who shall notify the local law enforcement agency and department in accordance with regulations promulgated by the department. The person making the request shall complete a form as prescribed by the commissioner, which shall include the name, address, telephone numbers and social security numbers of the person making the request. A motor vehicle operator's license, or if such license is not available, such other identification as the commissioner determines to be satisfactory, shall be presented, photocopied and returned to [him or her] them. When a copy of the birth certificate of a person whose record has been flagged is requested in writing, the registrar shall notify the local law enforcement agency and the department in accordance with regulations promulgated by the department.

§ 5. Subdivisions 2, 3, 8, and 9 of section 4174 of the public health law, subdivisions 2 and 3 as amended by section 2 and subdivision 9 as added by section 3 of part W2 of chapter 62 of the laws of 2003 and subdivision 8 as added by chapter 690 of the laws of 1994, are amended to read as follows:

2. Each applicant for a certification of birth or death, certificate of birth data or for a certified copy or certified transcript of a birth or death certificate or certificate of birth data shall remit to the commissioner with such application a fee of [thirty] forty-five dollars in payment for the search of the files and records and the furnishing of a certification, certified copy or certified transcript if such record is found or for a certification that a search discloses no record of a birth or of a death.

3. [For any] Regarding requests to search [of the files and] vital records [conducted] for authorized genealogical or research purposes[, the commissioner or any person authorized by him shall be entitled to, and the applicant shall pay, a fee of twenty dollars for each hour or fractional part of an hour of time of search, together with a fee of two dollars for each uncertified copy or abstract of such record requested by the applicant or for a certification that a search discloses no record.]:

(a) Notwithstanding any contrary provision of law, the commissioner shall have the authority to determine the means and methods by which the following genealogical records may be released to an applicant meeting the qualifications to receive the relevant record type as described in this article or article three of the domestic relations law: (1) a record of birth which has been on file for at least one hundred twenty-five years, when the person to whom the record relates is known to be deceased, (2) a record of death which has been on file for at least seventy-five years, or (3) a record of marriage or dissolution of marriage which has been on file for at least one hundred years, when both parties to the marriage are known to be deceased. No such record or abstract of such record shall be subject to disclosure under article six of the public officers law.

(b) The commissioner or any person authorized by them shall have the authority to approve a request for records sought for research purposes. In the event that such approval is granted, the commissioner or any person authorized by them shall be entitled to, and the applicant shall pay, a fee of fifty dollars for each hour or fractional part of each hour of time devoted to search or retrieval of records, together with a fee of forty-five dollars for each uncertified copy or abstract of an individual record or for a certification that a search discloses no record.

8. The commissioner, the commissioner of health of the city of New York, or any person authorized by the commissioner having jurisdiction shall immediately notify the division of criminal justice services in the event that a copy of a birth certificate or information concerning the birth records of any person whose record is flagged pursuant to paragraph [(i)] (h) of subdivision two of section four thousand one hundred of this article is requested. In the event that a copy of the birth certificate of a person whose record is so flagged is requested in person, the personnel accepting the request shall immediately notify [his or her] their supervisor. The person making the request shall complete a form as prescribed by the commissioner or, in the city of New York, the commissioner of health of the city of New York, which shall include the name, address and telephone numbers and social security number of the person making the request. A motor vehicle operator's license, or if such license is not available, such other identification as the commissioner, or in the city of New York, the commissioner of the New York city department of health, determines to be satisfactory, of the person making the request shall be presented, shall be photocopied and returned to [him or her] them. The person receiving the request shall note the physical description of the person making the request and [his or her] their supervisor shall immediately notify the local law enforcement authority as to the request and the information obtained pursuant to this [subsection] subdivision. When a copy of the birth certificate of a person whose record has been flagged is requested in writing, the law enforcement authority having jurisdiction shall be notified as to the request and shall be provided with a copy of the written request. The registrar shall retain the original written response.

9. The commissioner may institute an additional fee of [fifteen] thirty dollars for priority handling for each certification, certified copy or certified transcript of certificates of birth, death, or dissolution of marriage; or [fifteen] thirty dollars for priority handling for each certification, certified copy or certified transcript of certificate of marriage.

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

PART V

Section 1. This part enacts into law major components of legislation relating to the scope of practice of certified nurse aides, medical assistants, pharmacists, and pharmacy technicians. Each component is wholly contained within a Subpart identified as Subparts A through F. The effective date for each particular provision contained within such 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 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. Section 6908 of the education law is amended by adding a new subdivision 3 to read as follows:

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

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

b. provide that medication-related tasks performed by certified medication aides may be performed only under appropriate supervision as determined by the commissioner of health;

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

(i) allowing assignment of medication-related tasks to a certified medication aide only where such certified medication aide has demonstrated to the satisfaction of the supervising registered professional nurse competency in every medication-related task that such certified medication aide is authorized to perform, a willingness to perform such medication-related tasks, and the ability to effectively and efficiently

communicate with the individual receiving services and understand such individual's needs;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 2. Section 6909 of the education law is amended by adding a new subdivision 12 to read as follows:

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

sixty-nine hundred eight of this article and supervise certified medication aides who perform assigned medication-related tasks.

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

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

§ 4. The commissioner of health shall, in consultation with the commissioner of education, issue a report on the implementation of certified medication aides in residential care facilities in the state two years after the effective date of this act. Such report shall include the number of certified medication aides authorized pursuant to this act; the impact, if any, that the introduction of certified medication aides had on workforce availability in residential care facilities and/or the retention of registered nurses and/or licensed practical nurses working in residential care facilities; the number of complaints pertaining to services provided by certified medication aides that were reported to the department of health; and the number of certified medication aides who had their authorization limited or revoked. Such report shall provide recommendations to the governor and the chairs of the senate and assembly health and higher education committees regarding the implementation of certified medication aides pursuant to this act, and any recommendations related thereto.

§ 5. This act shall take effect on the one hundred eightieth day after it shall have become a law and shall expire ten years following such effective date when upon such date the provisions of this act shall expire and be deemed repealed.

SUBPART B

Section 1. Section 6526 of the education law is amended by adding a new subdivision 9-a to read as follows:

9-a. A medical assistant when drawing and administering an immunization in an outpatient office setting under the direct supervision of a physician or a physician assistant.

§ 2. The public health law is amended by adding a new section 2113 to read as follows:

§ 2113. Administration of immunizations; medical assistants. Notwithstanding any other law, rule, or regulation to the contrary, physicians and physician assistants are hereby authorized to delegate the task of drawing up and administering immunizations to medical assistants in outpatient office settings provided such immunizations are recommended by the advisory committee for immunization practices (ACIP) of the Centers for Disease Control and Prevention; and provided further that medical assistants receive appropriate training and adequate supervision determined pursuant to regulations by the commissioner in consultation with the commissioner of education.

§ 3. 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.

SUBPART C

Section 1. Paragraph (a) and (b) of subdivision 7 of section 6527 of the education law, as amended by chapter 555 of the laws of 2021, are amended to read as follows:

(a) administering immunizations to prevent influenza and COVID-19 to patients two years of age or older; and (b) administering immunizations to prevent pneumococcal, acute herpes zoster, hepatitis A, hepatitis B, human papillomavirus, measles, mumps, rubella, varicella, [COVID-19,] meningococcal, tetanus, diphtheria or pertussis disease and medications required for emergency treatment of anaphylaxis to patients eighteen years of age or older; and

§ 2. Paragraph (b) of subdivision 4 of section 6801 of the education law, as amended by section 1 of part DD of chapter 57 of the laws of 2018, is amended to read as follows:

(b) education materials on influenza and COVID-19 vaccinations for children as determined by the commissioner and the commissioner of health.

§ 3. Subparagraph 2 of paragraph (a) of subdivision 22 of section 6802 of the education law, as amended by chapter 802 of the laws of 2022, is amended to read as follows:

(2) the direct application of an immunizing agent to children between the ages of two and eighteen years of age, whether by injection, ingestion, inhalation or any other means, pursuant to a patient specific order or non-patient specific regimen prescribed or ordered by a physician or certified nurse practitioner, for immunization to prevent influenza and COVID-19 and medications required for emergency treatment of anaphylaxis resulting from such immunization. If the commissioner of health determines that there is an outbreak of influenza or COVID-19, or that there is the imminent threat of an outbreak of influenza or COVID-19, then the commissioner of health may issue a non-patient specific regimen applicable statewide.

§ 4. Paragraphs (a) and (b) of subdivision 7 of section 6909 of the education law, as amended by chapter 555 of the laws of 2021, are amended to read as follows:

(a) administering immunizations to prevent influenza and COVID-19 to patients two years of age or older; and (b) administering immunizations to prevent pneumococcal, acute herpes zoster, hepatitis A, hepatitis B, human papillomavirus, measles, mumps, rubella, varicella, [COVID-19,] meningococcal, tetanus, diphtheria or pertussis disease and medications required for emergency treatment of anaphylaxis to patients eighteen years of age or older; and

§ 5. Subdivision 1 of section 6841 of the education law, as added by chapter 414 of the laws of 2019, is amended to read as follows:

1. (a) A registered pharmacy technician may, under the direct personal supervision of a licensed pharmacist, assist such licensed pharmacist, as directed, in compounding, preparing, labeling, or dispensing of drugs used to fill valid prescriptions or medication orders or in compounding, preparing, and labeling in anticipation of a valid prescription or medication order for a patient to be served by the facility, in accordance with article one hundred thirty-seven of this title where such tasks require no professional judgment. Such professional judgment shall only be exercised by a licensed pharmacist. A registered pharmacy technician may administer the same immunizations as licensed pharmacists are authorized to administer under the direct supervision of a licensed pharmacist consistent with the training and other requirements in article one hundred thirty-seven of this title. A registered pharmacy technician may only practice in a facility licensed in accordance with arti-

cle twenty-eight of the public health law, or a pharmacy owned and operated by such a facility, under the direct personal supervision of a licensed pharmacist employed in such a facility or pharmacy. Such facility shall be responsible for ensuring that the registered pharmacy technician has received appropriate training, in accordance with paragraph (b) of this subdivision, to ensure competence before [he or she] such registered pharmacy technician begins assisting a licensed pharmacist in compounding, administering immunizations, preparing, labeling, or dispensing of drugs, in accordance with this article and article one hundred thirty-seven of this title. For the purposes of this article, direct personal supervision means supervision of procedures based on instructions given directly by a supervising licensed pharmacist who remains in the immediate area where the procedures are being performed, authorizes the procedures and evaluates the procedures performed by the registered pharmacy technicians and a supervising licensed pharmacist shall approve all work performed by the registered pharmacy technician prior to the actual dispensing of any drug.

(b) No registered pharmacy technician shall administer immunizing agents without receiving training satisfactory to the commissioner, in consultation with the commissioner of health, as prescribed in regulations of the commissioner, which shall include, but not be limited to: techniques for screening individuals and obtaining informed consent; techniques of administration; indications, precautions, and contraindications in the use of an agent or agents; recordkeeping of immunization and information; and handling emergencies, including anaphylaxis and needlestick injuries. The registered pharmacy technician and the facility shall maintain documentation that the registered pharmacy technician has completed the required training, pursuant to regulations of the commissioner.

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

SUBPART D

Section 1. Section 6801 of the education law is amended by adding a new subdivision 10 to read as follows:

10. A licensed pharmacist within their lawful scope of practice may prescribe and order medications to treat nicotine dependence approved by the federal food and drug administration for smoking cessation.

§ 2. This act shall take effect nine months after it shall have become a law.

SUBPART E

Section 1. Notwithstanding any other provision of law, rule, or regulation to the contrary, the following articles of title 8 of the education law governing the healthcare professions are hereby REPEALED and all removed provisions, and all powers authorized pursuant to such provisions, are hereby added to the public health law under the authority of the commissioner of health, pursuant to a plan to be proposed not inconsistent with this section, which shall include the text of the new laws to be adopted.

Article 131 MEDICINE

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

Article 131-B PHYSICIAN ASSISTANTS

Article 131-C SPECIALIST ASSISTANTS

§ 2. Transfer of functions, powers, duties and obligations. Notwithstanding any inconsistent provisions of law to the contrary, effective January 1, 2026, all functions, powers, duties and obligations of the education department concerning the professions of medicine, physicians, physician assistants, and specialist assistants under title 8 of the education law shall be transferred to the New York state department of health.

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

§ 4. Continuity of authority. For the purpose of all functions, powers, duties and obligations of the state education department transferred to and assumed by the department of health, the department of health shall continue the operation of the provisions previously done by the state education department, pursuant to sections one through ten of this act.

§ 5. Completion of unfinished business. Any business or other matter undertaken or commenced by the state education department pertaining to or connected with the functions, powers, duties and obligations hereby transferred and assigned to the department of health and pending on the effective date of January 1, 2026 shall be conducted and completed by the department of health in the same manner and under the same terms and conditions and with the same effect as if conducted and completed by the state education department.

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

§ 7. Terms occurring in laws, contracts and other documents. Whenever the state education department is referred to or designated in any law, contract or document pertaining to the functions, powers, obligations and duties hereby transferred and assigned, such reference or designation shall be deemed to refer to department of health or the commissioner thereof.

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

§ 9. Pending actions or proceedings. No action or proceeding pending at the time when sections one through ten of this act shall take effect relating to the functions, powers and duties of the state education department transferred pursuant to sections one through eight of this act, brought by or against the state education department or board of regents shall be affected by any provision of this act, but the same may be prosecuted or defended in the name of the commissioner of the department of health. In all such actions and proceedings, the commissioner of health, upon application to the court, shall be substituted as a party.

§ 10. Transfer of appropriations heretofore made to the state education department. Upon the transfer pursuant to sections one through nine of this act of the functions and powers possessed by and of the obligations and duties of the education department, all appropriations and reappropriations which shall have been made available as of the date of

such transfer to the education department, or segregated pursuant to law, to the extent of remaining unexpended or unencumbered balances thereof, whether allocated or unallocated and whether obligated or unobligated, shall be transferred to and made available for use and expenditure by the department of health and shall be payable on vouchers certified or approved by the commissioner of taxation and finance, on audit and warrant of the comptroller. Payments of liabilities for expenses of personnel services, maintenance and operation which shall have been incurred as of the date of such transfer by the education department, and for liabilities incurred and to be incurred in completing its affairs, shall also be made on vouchers certified or approved by the commissioner of education on audit and warrant of the comptroller.

§ 11. This act shall take effect January 1, 2026.

SUBPART F

Section 1. Section 6542 of the education law, as amended by chapter 520 of the laws of 2024, is amended to read as follows:

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

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

(i) Where the physician assistant, licensed under section sixty-five hundred forty-one of this article has practiced for more than eight thousand hours within the same or a substantially similar specialty that the physician assistant seeks to practice in without supervision; and (A) is practicing in primary care. For purposes of this clause, "primary care" shall mean non-surgical care in the fields of general pediatrics, general adult medicine, general geriatric medicine, general internal medicine, obstetrics and gynecology, family medicine, or such other related areas as determined by the commissioner of health; or (B) is employed by a health system or hospital established under article twenty-eight of the public health law, and the health system or hospital determines the physician assistant meets the qualifications of the medical staff bylaws and the health system or hospital gives the physician assistant privileges; and

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

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

(c) In the event that a physician assistant seeks to practice in a substantially different specialty, the physician assistant shall complete at least eight thousand hours of practice in such new specialty before such physician assistant may practice without physician supervision pursuant to subdivision (a) of this section.

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

3. [No physician shall employ or supervise more than six physician assistants in such physician's private practice at one time.

4.] Nothing in this article shall prohibit a hospital from employing physician assistants, provided that they [work under the supervision of a physician designated by the hospital and not beyond the scope of practice of such physician. The numerical limitation of subdivision three of this section shall not apply to services performed in a hospital.

5. Notwithstanding any other provision of this article, nothing shall prohibit a physician employed by or rendering services to the department of corrections and community supervision under contract from supervising no more than eight physician assistants in such physician's practice for the department of corrections and community supervision at one time.

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

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

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

6. A physician assistant may prescribe and order a non-patient specific regimen to a registered professional nurse, pursuant to regulations promulgated by the commissioner, and consistent with the public health law, for:

(a) administering immunizations.

(b) the emergency treatment of anaphylaxis.

(c) administering purified protein derived (PPD) tests or other tests to detect or screen for tuberculosis infections.

(d) administering tests to determine the presence of the human immunodeficiency virus.

(e) administering tests to determine the presence of the hepatitis C virus.

(f) the urgent or emergency treatment of opioid related overdose or suspected opioid related overdose.

(g) screening of persons at increased risk of syphilis, gonorrhea, and chlamydia.

(h) administering electrocardiogram tests to detect signs and symptoms of acute coronary syndrome.

(i) administering point-of-care blood glucose tests to evaluate acute mental status changes in persons with suspected hypoglycemia.

(j) administering tests and intravenous lines to persons that meet severe sepsis and septic shock criteria.

(k) administering tests to determine pregnancy.

(l) administering tests to determine the presence of COVID-19 or its antibodies or influenza virus.

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

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

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

§ 3. Section 3702 of the public health law, as amended by section 48 of the laws of 2012, and subdivision 1 as amended by chapter 520 of the laws of 2024, is amended to read as follows:

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

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

3. Prescriptions for controlled substances. A licensed physician assistant, in good faith and acting within [his or her] such physician assistant's lawful scope of practice, and to the extent assigned by [his or her] the supervising physician as applicable under section sixty-five hundred forty-two of the education law, may prescribe controlled substances as a practitioner under article thirty-three of this chapter, to patients under the care of such physician responsible for [his or her] such physician assistant's supervision. The commissioner, in consultation with the commissioner of education, may promulgate such regulations as are necessary to carry out the purposes of this section.

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

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

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

a. The board of education, and the trustee or board of trustees of each school district, shall employ, at a compensation to be agreed upon by the parties, a qualified physician, a physician assistant, or a nurse

practitioner to the extent authorized by the nurse practice act and consistent with subdivision three of section six thousand nine hundred two of this chapter, to perform the duties of the director of school health services, including any duties conferred on the school physician or school medical inspector under any provision of law, to perform and coordinate the provision of health services in the public schools and to provide health appraisals of students attending the public schools in the city or district. The physicians, physician assistants, or nurse practitioners so employed shall be duly licensed pursuant to applicable law.

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

27. "Practitioner" means:

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

§ 7. This act shall take effect December 31, 2025; provided, however, that if the provisions of chapter 520 of the laws of 2024 have taken effect on or before such date, then sections one and three of this act shall take effect on the same date and in the same manner as such chapter of the laws of 2024 takes effect; and provided further, however, that the amendments to paragraph (1) of subdivision 7 of section 6542 of the education law made by section one of this act shall not affect the repeal of such paragraph and shall be deemed repealed therewith.

§ 2. Severability clause. If any clause, sentence, paragraph, subdivision, section, or subpart of this part shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair, or invalidate the remainder of that subpart or this part, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section, or subpart 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 part and each subpart herein would have been enacted even if such invalid provisions had not been included herein.

§ 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2025; provided, however, that the applicable effective dates of Subparts A through F of this act shall be as specifically set forth in the last section of such Subparts.

PART W

Section 1. Article 170 of the education law is renumbered article 171 and a new article 170 is added to title 8 of the education law to read as follows:

ARTICLE 170
NURSE LICENSURE COMPACT

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

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

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

b. Violations of nurse licensure and other laws regulating the practice of nursing may result in injury or harm to the public;

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

d. New practice modalities and technology make compliance with individual state nurse licensure laws difficult and complex;

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

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

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

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

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

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

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

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

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

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

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

a. "Adverse action" means any administrative, civil, equitable or criminal action permitted by a state's laws which is imposed by a licensing board or other authority against a nurse, including actions against an individual's license or multistate licensure privilege such

as revocation, suspension, probation, monitoring of the licensee, limitation on the licensee's practice, or any other encumbrance on licensure affecting a nurse's authorization to practice, including issuance of a cease and desist action.

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

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

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

e. "Current significant investigative information" means:

1. Investigative information that a licensing board, after a preliminary inquiry that includes notification and an opportunity for the nurse to respond, if required by state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction; or

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

f. "Encumbrance" means a revocation or suspension of, or any limitation on, the full and unrestricted practice of nursing imposed by a licensing board.

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

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

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

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

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

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

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

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

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

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

§ 8903. General provisions and jurisdiction. 1. General provisions and jurisdiction. a. A multistate license to practice registered or licensed practical/vocational nursing issued by a home state to a resident in

that state will be recognized by each party state as authorizing a nurse to practice as a registered nurse (RN) or as a licensed practical/vocational nurse (LPN/VN), under a multistate licensure privilege, in each party state.

b. A state shall implement procedures for considering the criminal history records of applicants for an initial multistate license or licensure by endorsement. Such procedures shall include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant's criminal history record information from the federal bureau of investigation and the agency responsible for retaining that state's criminal records.

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

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

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

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

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

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

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

vi. Has submitted, in connection with an application for initial licensure or licensure by endorsement, fingerprints or other biometric data for the purpose of obtaining criminal history record information from the federal bureau of investigation and the agency responsible for retaining that state's criminal records;

vii. Has not been convicted or found guilty, or has entered into an agreed disposition, of a felony offense under applicable state or federal criminal law;

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

ix. Is not currently enrolled in an alternative program;

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

xi. Has a valid United States social security number.

d. All party states shall be authorized, in accordance with existing state due process law, to take adverse action against a nurse's multistate licensure privilege such as revocation, suspension, probation or any other action that affects a nurse's authorization to practice under a multistate licensure privilege, including cease and desist actions. If a party state takes such action, it shall promptly notify the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the home state of any such actions by remote states.

e. A nurse practicing in a party state shall comply with the state practice laws of the state in which the client is located at the time

service is provided. The practice of nursing is not limited to patient care but shall include all nursing practice as defined by the state practice laws of the party state in which the client is located. The practice of nursing in a party state under a multistate licensure privilege will subject a nurse to the jurisdiction of the licensing board, the courts and the laws of the party state in which the client is located at the time service is provided.

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

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

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

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

§ 8904. Applications for licensure in a party state. 1. Applications for licensure in a party state. a. Upon application for a multistate license, the licensing board in the issuing party state shall ascertain, through the coordinated licensure information system, whether the applicant has ever held, or is the holder of, a license issued by any other state, whether there are any encumbrances on any license or multistate licensure privilege held by the applicant, whether any adverse action has been taken against any license or multistate licensure privilege held by the applicant and whether the applicant is currently participating in an alternative program.

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

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

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

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

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

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

a. Take adverse action against a nurse's multistate licensure privilege to practice within that party state.

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

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

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

c. Complete any pending investigations of a nurse who changes primary state of residence during the course of such investigations. The licensing board shall also have the authority to take appropriate action or actions and shall promptly report the conclusions of such investigations to the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the new home state of any such actions.

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

e. Obtain and submit, for each nurse licensure applicant, fingerprint or other biometric-based information to the federal bureau of investigation for criminal background checks, receive the results of the federal bureau of investigation record search on criminal background checks and use the results in making licensure decisions.

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

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

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

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

§ 8906. Coordinated licensure information system and exchange of information. 1. Coordinated licensure information system and exchange of information. a. All party states shall participate in a coordinated licensure information system of all licensed registered nurses (RNs) and

licensed practical/vocational nurses (LPNs/VNs). This system will include information on the licensure and disciplinary history of each nurse, as submitted by party states, to assist in the coordination of nurse licensure and enforcement efforts.

b. The commission, in consultation with the administrator of the coordinated licensure information system, shall formulate necessary and proper procedures for the identification, collection and exchange of information under this compact.

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

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

e. Notwithstanding any other provision of law, all party state licensing boards contributing information to the coordinated licensure information system may designate information that may not be shared with non-party states or disclosed to other entities or individuals without the express permission of the contributing state.

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

g. Any information contributed to the coordinated licensure information system that is subsequently required to be expunged by the laws of the party state contributing that information shall also be expunged from the coordinated licensure information system.

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

i. Identifying information;

ii. Licensure data;

iii. Information related to alternative program participation; and

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

i. The compact administrator of a party state shall provide all investigative documents and information requested by another party state.

§ 8907. Establishment of the interstate commission of nurse licensure compact administrators. 1. Commission of nurse licensure compact administrators. The party states hereby create and establish a joint public entity known as the interstate commission of nurse licensure compact administrators. The commission is an instrumentality of the party states.

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

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

4. Membership, voting and meetings. a. Each party state shall have and be limited to one administrator. The head of the state licensing board or designee shall be the administrator of this compact for each party state. Any administrator may be removed or suspended from office as provided by the law of the state from which the administrator is appointed. Any vacancy occurring in the commission shall be filled in accordance with the laws of the party state in which the vacancy exists.

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

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

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

5. Closed meetings. a. The commission may convene in a closed, nonpublic meeting if the commission shall discuss:

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

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

iii. Current, threatened or reasonably anticipated litigation;

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

v. Accusing any person of a crime or formally censuring any person;

vi. Disclosure of trade secrets or commercial or financial information that is privileged or confidential;

vii. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

viii. Disclosure of investigatory records compiled for law enforcement purposes;

ix. Disclosure of information related to any reports prepared by or on behalf of the commission for the purpose of investigation of compliance with this compact; or

x. Matters specifically exempted from disclosure by federal or state statute.

b. If a meeting, or portion of a meeting, is closed pursuant to this paragraph the commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefor, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the commission or order of a court of competent jurisdiction.

c. The commission shall, by a majority vote of the administrators, prescribe bylaws or rules to govern its conduct as may be necessary or

appropriate to carry out the purposes and exercise the powers of this compact, including but not limited to:

i. Establishing the fiscal year of the commission;

ii. Providing reasonable standards and procedures:

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

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

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

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

v. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the commission. Notwithstanding any civil service or other similar laws of any party state, the bylaws shall exclusively govern the personnel policies and programs of the commission; and

vi. Providing a mechanism for winding up the operations of the commission and the equitable disposition of any surplus funds that may exist after the termination of this compact after the payment or reserving of all of its debts and obligations.

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

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

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

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

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

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

c. To purchase and maintain insurance and bonds;

d. To borrow, accept or contract for services of personnel, including, but not limited to, employees of a party state or nonprofit organizations;

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

f. To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of this compact, and to establish the commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel and other related personnel matters;

g. To accept any and all appropriate donations, grants and gifts of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the commission shall avoid any appearance of impropriety or conflict of interest;

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

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

j. To establish a budget and make expenditures;

k. To borrow money;

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

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

n. To adopt and use an official seal; and

o. To perform such other functions as may be necessary or appropriate to achieve the purposes of this compact consistent with the state regulation of nurse licensure and practice.

8. Financing of the commission. a. The commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization and ongoing activities.

b. The commission may also levy on and collect an annual assessment from each party state to cover the cost of its operations, activities and staff in its annual budget as approved each year. The aggregate annual assessment amount, if any, shall be allocated based upon a formula to be determined by the commission, which shall promulgate a rule that is binding upon all party states.

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

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

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

b. The commission shall defend any administrator, officer, executive director, employee or representative of the commission in any civil

action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of the commission's employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of the commission's employment, duties or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining such person's own counsel; and provided further that the actual or alleged act, error or omission did not result from that person's intentional, willful or wanton misconduct.

c. The commission shall indemnify and hold harmless any administrator, officer, executive director, employee or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of the commission's employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of the commission's employment, duties or responsibilities, provided that the actual or alleged act, error or omission did not result from the intentional, willful or wanton misconduct of that person.

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

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

2. Notice. a. Prior to promulgation and adoption of a final rule or rules by the commission, and at least sixty days in advance of the meeting at which the rule will be considered and voted upon, the commission shall file a notice of proposed rulemaking:

i. On the website of the commission; and

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

b. The notice of proposed rulemaking shall include:

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

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

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

iv. The manner in which interested persons may submit notice to the commission of their intention to attend the public hearing and any written comments.

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

3. Public hearings on rules. a. The commission shall grant an opportunity for a public hearing before it adopts a rule or amendment.

b. The commission shall publish the place, time and date of the scheduled public hearing.

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

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

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

d. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the commission shall consider all written and oral comments received.

4. Voting on rules. The commission shall, by majority vote of all administrators, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

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

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

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

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

6. Revisions. The commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency or grammatical errors. Public notice of any revisions shall be posted on the website of the commission. The revision shall be subject to challenge by any person for a period of thirty days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing, and delivered to the commission, prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the commission.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. Nothing contained in this compact shall be construed to invalidate or prevent any nurse licensure agreement or other cooperative arrangement between a party state and a non-party state that is made in accordance with the other provisions of this compact.

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

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

§ 8911. Construction and severability. 1. Construction and severability. This compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this compact shall be severable, and if any phrase, clause, sentence or provision of this compact is declared to be contrary to the constitution of any party state or of the United States, or if the applicability thereof to any government, agency, person or circumstance is held to be invalid, the validity of the remainder of this compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this compact shall be held to be contrary to the constitution of any party state, this compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters.

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

PART X

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

§ 6605-b. Dental hygiene restricted local infiltration and block anesthesia/nitrous oxide analgesia certificate. 1. A dental hygienist shall not administer or monitor nitrous oxide analgesia or local infiltration or block anesthesia in the practice of dental hygiene without a dental hygiene restricted local infiltration and block

anesthesia/nitrous oxide analgesia certificate and except under the personal supervision of a dentist and in accordance with regulations promulgated by the commissioner. Personal supervision, for purposes of this section, means that the supervising dentist remains in the dental office where the local infiltration or block anesthesia or nitrous oxide analgesia services are being performed, personally authorizes and prescribes the use of local infiltration or block anesthesia or nitrous oxide analgesia for the patient and, before dismissal of the patient, personally examines the condition of the patient after the use of local infiltration or block anesthesia or nitrous oxide analgesia is completed. It is professional misconduct for a dentist to fail to provide the supervision required by this section, and any dentist found guilty of such misconduct under the procedures prescribed in section sixty-five hundred ten of this title shall be subject to the penalties prescribed in section sixty-five hundred eleven of this title.

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

3. The fee for a dental hygiene restricted local infiltration and block anesthesia/nitrous oxide analgesia certificate shall be twenty-five dollars and shall be paid on a triennial basis upon renewal of such certificate. A certificate may be suspended or revoked in the same manner as a license to practice dental hygiene.

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

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

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

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

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

2. (a) The collaborative practice agreement shall include consideration for medically compromised patients, specific medical conditions, and age-and procedure-specific practice protocols, including, but not limited to recommended intervals for the performance of dental hygiene services and a periodicity in which an examination by a dentist should occur.

(b) The collaborative agreement shall be:

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

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

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

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

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

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

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

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

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

PART Y

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

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

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

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

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

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

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

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

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

PART Z

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

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

§ 2. This act shall take effect immediately.

PART AA

Section 1. Section 2 of part NN of chapter 58 of the laws of 2015, amending the mental hygiene law relating to clarifying the authority of the commissioners in the department of mental hygiene to design and implement time-limited demonstration programs, as amended by section 1 of part Z of chapter 57 of the laws of 2024, is amended to read as follows:

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

§ 2. This act shall take effect immediately.

PART BB

Section 1. Section 4 of part L of chapter 59 of the laws of 2016, amending the mental hygiene law relating to the appointment of temporary operators for the continued operation of programs and the provision of services for persons with serious mental illness and/or developmental disabilities and/or chemical dependence, as amended by section 1 of part OO of chapter 57 of the laws of 2022, is amended to read as follows:

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

§ 2. This act shall take effect immediately.

PART CC

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

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

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

PART DD

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

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

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

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

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

1. Any person who is eighteen years of age or older, or is the parent of a child or has married, or is a homeless youth as defined in section five hundred thirty-two-a of the executive law, or receives services at an approved runaway and homeless youth crisis services program or a transitional independent living support program as defined in section five hundred thirty-two-a of the executive law, may give effective consent for medical, dental, health and hospital services, including behavioral health services, for themself, and the consent of no other person shall be necessary.

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

PART EE

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

"in need of involuntary care and treatment" means that a person has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that [he] the person is unable to understand the need for such care and treatment.

"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] themself, or (b) 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, or (c) a substantial risk of physical harm to the person due to an inability or refusal, as a result of their mental illness, to provide for their

own essential needs such as food, clothing, medical care, safety, or shelter.

§ 2. The mental hygiene law is amended by adding a new section 9.04 to read as follows:

§ 9.04 Clinical determination of likelihood to result in serious harm.

In making a clinical determination of whether a person's mental illness is likely to result in serious harm to self or others, the evaluating clinician shall review:

1. medical records available to the evaluating clinician;

2. all credible reports of the person's recent behavior;

3. any credible, known information related to the person's medical and behavioral history; and

4. any other available relevant information.

§ 3. Subdivisions (a), (d), (e), and (i) of section 9.27 of the mental hygiene law, as renumbered by chapter 978 of the laws of 1977 and subdivision (i) as amended by chapter 847 of the laws of 1987, are amended to read as follows:

(a) The director of a hospital may receive and retain therein as a patient any person alleged to be mentally ill and in need of involuntary care and treatment upon the [certificate] certificates of two examining physicians, or upon the certificates of an examining physician and a psychiatric nurse practitioner. Such certificates shall be accompanied by an application for the admission of such person. The examination may be conducted jointly but each [examining physician] certifying practitioner shall execute a separate certificate.

(d) Before an examining physician or psychiatric nurse practitioner completes the certificate of examination of a person for involuntary care and treatment, [he] they shall consider alternative forms of care and treatment that might be adequate to provide for the person's needs without requiring involuntary hospitalization. If the examining physician or psychiatric nurse practitioner knows that the person [he is] they are examining for involuntary care and treatment has been under prior treatment, [he] they shall, insofar as possible, consult with the physician or psychologist furnishing such prior treatment prior to completing [his] their certificate. Nothing in this section shall prohibit or invalidate any involuntary admission made in accordance with the provisions of this chapter.

(e) The director of the hospital where such person is brought shall cause such person to be examined forthwith by a physician who shall be a member of the psychiatric staff of such hospital other than the original examining physicians or psychiatric nurse practitioner whose certificate or certificates accompanied the application and, if such person is found to be in need of involuntary care and treatment, [he] they may be admitted thereto as a patient as herein provided.

(i) After an application for the admission of a person has been completed and both [physicians] certifying practitioners have examined such person and separately certified that [he or she] such person is mentally ill and in need of involuntary care and treatment in a hospital, either [physician] certifying practitioner is authorized to request 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 take into custody and transport such person to a hospital for determination by the director whether such person qualifies for admission pursuant to this section. Upon the request of either [physician] certifying practitioner, an ambulance service, as defined by subdivision two of section three thousand one of

the public health law, is authorized to transport such person to a hospital for determination by the director whether such person qualifies for admission pursuant to this section.

§ 4. Subsection (a) of section 9.37 of the mental hygiene law, as renumbered by chapter 978 of the laws of 1977, is amended to read as follows:

(a) The director of a hospital, upon application by a director of community services or an examining physician duly designated by [him] them, may receive and care for in such hospital as a patient any person who, in the opinion of the director of community services or [his] their designee, has a mental illness for which immediate inpatient care and treatment in a hospital is appropriate and which is likely to result in serious harm to [himself] themself or others; "likelihood of serious harm" shall mean:

1. substantial risk of physical harm to [himself] themself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that [he is] they are dangerous to [himself] themself, or

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 or serious physical harm[.]; or

3. a substantial risk of physical harm to the person due to an inability or refusal, as a result of their mental illness, to provide for their own essential needs such as food, clothing, medical care, safety, or shelter.

The need for immediate hospitalization shall be confirmed by a staff physician of the hospital prior to admission. Within seventy-two hours, excluding Sunday and holidays, after such admission, if such patient is to be retained for care and treatment beyond such time and [he does] they do not agree to remain in such hospital as a voluntary patient, the certificate of another examining physician who is a member of the psychiatric staff of the hospital that the patient is in need of involuntary care and treatment shall be filed with the hospital. From the time of [his] their admission under this section the retention of such patient for care and treatment shall be subject to the provisions for notice, hearing, review, and judicial approval of continued retention or transfer and continued retention provided by this article for the admission and retention of involuntary patients, provided that, for the purposes of such provisions, the date of admission of the patient shall be deemed to be the date when the patient was first received in the hospital under this section.

§ 5. Subsection (a) of section 9.39 of the mental hygiene law, as amended by chapter 789 of the laws of 1985, is amended to read as follows:

(a) The director of any hospital maintaining adequate staff and facilities for the observation, examination, care, and treatment of persons alleged to be mentally ill and approved by the commissioner to receive and retain patients pursuant to this section may receive and retain therein as a patient for a period of fifteen days any person alleged to have a mental illness for which immediate observation, care, and treatment in a hospital is appropriate and which is likely to result in serious harm to [himself] themself or others. "Likelihood to result in serious harm" as used in this article shall mean:

1. substantial risk of physical harm to [himself] themself as manifested by threats of or attempts at suicide or serious bodily harm or

other conduct demonstrating that [he is] they are dangerous to [himself] themself, or

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[.], or

3. a substantial risk of physical harm to the person due to an inability or refusal, as a result of their mental illness, to provide for their own essential needs such as food, clothing, medical care, safety, or shelter.

§ 6. Subdivision (a) of section 9.45 of the mental hygiene law, as amended by section 6 of part AA of chapter 57 of the laws of 2021, is amended to read as follows:

(a) 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] their 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, if the parent, adult sibling, spouse [or], domestic partner as defined in section twenty-nine hundred ninety-four-a of the public health law, child of the person, cohabitant of the person's residential unit, 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] the director of community services or the director's designee that such person has a mental illness for which immediate care and treatment is appropriate and [which] that is likely to result in serious harm to [himself or herself] self 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.

§ 7. Subparagraph (iii) of paragraph 4 and paragraph 7 of subdivision (c), subparagraph (ii) of paragraph 1 of subdivision (e), paragraph 2 of subdivision (h), and paragraph 3 of subdivision (i) of section 9.60 of the mental hygiene law, as amended by chapter 158 of the laws of 2005, and subparagraph (iii) of paragraph 4 of subdivision (c) and paragraph 2 of subdivision (h) as amended by section 2 of subpart H of part UU of chapter 56 of the laws of 2022, are amended to read as follows:

(iii) notwithstanding subparagraphs (i) and (ii) of this paragraph, resulted in the issuance of a court order for assisted outpatient treatment [which] that has expired within the last six months, and since the expiration of the order[,]; (a) the person has experienced a substantial increase in symptoms of mental illness [and such symptoms] that substantially interferes with or limits [one or more major life activities as determined by a director of community services who previously was

required to coordinate and monitor the care of any individual who was subject to such expired assisted outpatient treatment order. The applicable director of community services or their designee shall arrange for the individual to be evaluated by a physician. If the physician determines court ordered services are clinically necessary and the least restrictive option, the director of community services may initiate a court proceeding.] the person's ability to maintain their health or safety; or (b) the person, due to a lack of compliance with recommended treatment, has received emergency treatment or inpatient care or has been incarcerated;

(7) is likely to benefit from assisted outpatient treatment. Previous non-compliance with court oversight or mandated treatment shall not preclude a finding that the person is likely to benefit from assisted outpatient treatment.

(ii) the parent, spouse, domestic partner, sibling eighteen years of age or older, or child eighteen years of age or older of the subject of the petition; or

(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 or by video-conference at the hearing. [Provided however, a physician shall only be authorized to testify by video conference when it has been: (i) shown that diligent efforts have been made to attend such hearing in person and the subject of the petition consents to the physician testifying by video conference; or (ii) the court orders the physician to testify by video conference upon a finding of good cause.] 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.

(3) The court shall not order assisted outpatient treatment unless a physician appearing on behalf of a director testifies in person or by video conference to explain the written proposed treatment plan. Such physician shall state the categories of assisted outpatient treatment recommended, the rationale for each such category, facts which establish that such treatment is the least restrictive alternative, and, if the recommended assisted outpatient treatment plan includes medication, such physician shall state the types or classes of medication recommended, the beneficial and detrimental physical and mental effects of such medication, and whether such medication should be self-administered or administered by an authorized professional. If the subject of the petition has executed a health care proxy, such physician shall state the consideration given to any directions included in such proxy in developing the written treatment plan. If a director is the petitioner, testimony pursuant to this paragraph shall be given at the hearing on the petition. If a person other than a director is the petitioner, such testimony shall be given on the date set by the court pursuant to paragraph three of subdivision (j) of this section.

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

§ 9.64 Notice of admission determination to community provider.

Upon an admission to a hospital or received as a patient in a comprehensive psychiatric emergency program pursuant to the provisions of this article, the director of such hospital or program shall ensure that reasonable efforts are made to identify and promptly notify of such

determination any community provider of mental health services that maintains such person on its caseload.

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

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

§ 10. This act shall take effect ninety days after it shall have become a law; provided, however, section four of this act shall take effect on the same date as the reversion of subsection (a) of section 9.37 of the mental hygiene law as provided in section 21 of chapter 723 of the laws of 1989, as amended; provided further, however, the amendments to section 9.45 of the mental hygiene law made by section six of this act shall not affect the repeal of such section and shall be deemed repealed therewith; and provided further, however, the amendments to section 9.60 of the mental hygiene law made by section seven of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART FF

Section 1. 1. Subject to available appropriations and approval of the director of the budget, the commissioners of the office of mental health, office for people with developmental disabilities, office of addiction services and supports, office of temporary and disability assistance, office of children and family services, and the state office for the aging (hereinafter "the commissioners") shall establish a state fiscal year 2025-2026 targeted inflationary increase, effective April 1, 2025, for projecting for the effects of inflation upon rates of payments, contracts, or any other form of reimbursement for the programs and services listed in subdivision four of this section. The targeted inflationary increase established herein shall be applied to the appro-

priate portion of reimbursable costs or contract amounts. Where appropriate, transfers to the department of health (DOH) shall be made as reimbursement for the state and/or local share of medical assistance.

2. Notwithstanding any inconsistent provision of law, subject to the approval of the director of the budget and available appropriations therefor, for the period of April 1, 2025 through March 31, 2026, the commissioners shall provide funding to support a two and one-tenth percent (2.1%) targeted inflationary increase under this section for all eligible programs and services as determined pursuant to subdivision four of this section.

3. Notwithstanding any inconsistent provision of law, and as approved by the director of the budget, the 2.1 percent targeted inflationary increase established herein shall be inclusive of all other inflationary increases, cost of living type increases, inflation factors, or trend factors that are newly applied effective April 1, 2025. Except for the 2.1 percent targeted inflationary increase established herein, for the period commencing on April 1, 2025 and ending March 31, 2026 the commissioners shall not apply any other new targeted inflationary increases or cost of living adjustments for the purpose of establishing rates of payments, contracts or any other form of reimbursement. The phrase "all other inflationary increases, cost of living type increases, inflation factors, or trend factors" as defined in this subdivision shall not include payments made pursuant to the American Rescue Plan Act or other federal relief programs related to the Coronavirus Disease 2019 (COVID-19) pandemic public health emergency. This subdivision shall not prevent the office of children and family services from applying additional trend factors or staff retention factors to eligible programs and services under paragraph (v) of subdivision four of this section.

4. Eligible programs and services. (i) Programs and services funded, licensed, or certified by the office of mental health (OMH) eligible for the targeted inflationary increase established herein, pending federal approval where applicable, include: office of mental health licensed outpatient programs, pursuant to parts 587 and 599 of title 14 CRR-NY of the office of mental health regulations including clinic (mental health outpatient treatment and rehabilitative services programs), continuing day treatment, day treatment, intensive outpatient programs and partial hospitalization; outreach; crisis residence; crisis stabilization, crisis/respite beds; mobile crisis, part 590 comprehensive psychiatric emergency program services; crisis intervention; home based crisis intervention; family care; supported single room occupancy; supported housing programs/services excluding rent; treatment congregate; supported congregate; community residence - children and youth; treatment/apartment; supported apartment; community residence single room occupancy; on-site rehabilitation; employment programs; recreation; respite care; transportation; psychosocial club; assertive community treatment; case management; care coordination, including health home plus services; local government unit administration; monitoring and evaluation; children and youth vocational services; single point of access; school-based mental health program; family support children and youth; advocacy/support services; drop in centers; recovery centers; transition management services; bridger; home and community based waiver services; behavioral health waiver services authorized pursuant to the section 1115 MRT waiver; self-help programs; consumer service dollars; conference of local mental hygiene directors; multicultural initiative; ongoing integrated supported employment services; supported education; mentally ill/chemical abuse (MICA) network; personalized recovery

oriented services; children and family treatment and support services; residential treatment facilities operating pursuant to part 584 of title 14-NYCRR; geriatric demonstration programs; community-based mental health family treatment and support; coordinated children's service initiative; homeless services; and promise zones.

(ii) Programs and services funded, licensed, or certified by the office for people with developmental disabilities (OPWDD) eligible for the targeted inflationary increase established herein, pending federal approval where applicable, include: local/unified services; chapter 620 services; voluntary operated community residential services; article 16 clinics; day treatment services; family support services; 100% day training; epilepsy services; traumatic brain injury services; hepatitis B services; independent practitioner services for individuals with intellectual and/or developmental disabilities; crisis services for individuals with intellectual and/or developmental disabilities; family care residential habilitation; supervised residential habilitation; supportive residential habilitation; respite; day habilitation; prevocational services; supported employment; community habilitation; intermediate care facility day and residential services; specialty hospital; pathways to employment; intensive behavioral services; community transition services; family education and training; fiscal intermediary; support broker; and personal resource accounts.

(iii) Programs and services funded, licensed, or certified by the office of addiction services and supports (OASAS) eligible for the targeted inflationary increase established herein, pending federal approval where applicable, include: medically supervised withdrawal services - residential; medically supervised withdrawal services - outpatient; medically managed detoxification; inpatient rehabilitation services; outpatient opioid treatment; residential opioid treatment; residential opioid treatment to abstinence; problem gambling treatment; medically supervised outpatient; outpatient rehabilitation; specialized services substance abuse programs; home and community based waiver services pursuant to subdivision 9 of section 366 of the social services law; children and family treatment and support services; continuum of care rental assistance case management; NY/NY III post-treatment housing; NY/NY III housing for persons at risk for homelessness; permanent supported housing; youth clubhouse; recovery community centers; recovery community organizing initiative; residential rehabilitation services for youth (RRSY); intensive residential; community residential; supportive living; residential services; job placement initiative; case management; family support navigator; local government unit administration; peer engagement; vocational rehabilitation; HIV early intervention services; dual diagnosis coordinator; problem gambling resource centers; problem gambling prevention; prevention resource centers; primary prevention services; other prevention services; comprehensive outpatient clinic; jail-based supports; and regional addiction resource centers.

(iv) Programs and services funded, licensed, or certified by the office of temporary and disability assistance (OTDA) eligible for the targeted inflationary increase established herein, pending federal approval where applicable, include: the nutrition outreach and education program (NOEP).

(v) Programs and services funded, licensed, or certified by the office of children and family services (OCFS) eligible for the targeted inflationary increase established herein, pending federal approval where applicable, include: programs for which the office of children and family services establishes maximum state aid rates pursuant to section

398-a of the social services law and section 4003 of the education law; emergency foster homes; foster family boarding homes and therapeutic foster homes; supervised settings as defined by subdivision twenty-two of section 371 of the social services law; adoptive parents receiving adoption subsidy pursuant to section 453 of the social services law; and congregate and scattered supportive housing programs and supportive services provided under the NY/NY III supportive housing agreement to young adults leaving or having recently left foster care.

(vi) Programs and services funded, licensed, or certified by the state office for the aging (SOFA) eligible for the targeted inflationary increase established herein, pending federal approval where applicable, include: community services for the elderly; expanded in-home services for the elderly; and the wellness in nutrition program.

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

6. Notwithstanding any inconsistent provision of law to the contrary, agency commissioners shall be authorized to recoup funding from a local governmental unit or direct contract provider for the targeted inflationary increase established herein determined to have been used in a manner inconsistent with the appropriation, or any other provision of this section. Such agency commissioners shall be authorized to employ any legal mechanism to recoup such funds, including an offset of other funds that are owed to such local governmental unit or direct contract provider.

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

§ 2. Severability clause. If any clause, sentence, paragraph, subdivision, section or part of this act shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which such judgment shall have been rendered. It is hereby declared to be the intent of the legislature that this act would have been enacted even if such invalid provisions had not been included herein.

§ 3. This act shall take effect immediately provided, however, that the applicable effective date of Parts A through FF of this act shall be as specifically set forth in the last section of such Parts.