

2078--A

2013-2014 Regular Sessions

I N   S E N A T E

January 10, 2013

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Introduced by Sens. PERKINS, AVELLA, BRESLIN, ESPAILLAT, HASSELL-THOMPSON, HOYLMAN, KRUEGER, LATIMER, MONTGOMERY, PARKER, PERALTA, RIVERA, SAMPSON, SERRANO, STAVISKY, TKACZYK -- read twice and ordered printed, and when printed to be committed to the Committee on Health -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the public health law and the state finance law, in relation to establishing New York Health

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

1     Section 1. Legislative findings and intent. 1. The state constitution  
2 states: "The protection and promotion of the health of the inhabitants  
3 of the state are matters of public concern and provision therefor shall  
4 be made by the state and by such of its subdivisions and in such manner,  
5 and by such means as the legislature shall from time to time determine."  
6 (Article XVII, S3.) The legislature finds and declares that all resi-  
7 dents of the state have the right to health care. New Yorkers - as indi-  
8 viduals, employers, and taxpayers - have experienced a rapid rise in the  
9 cost of health care and coverage in recent years. This increase has  
10 resulted in a large number of people without health coverage. Businesses  
11 have also experienced extraordinary increases in the costs of health  
12 care benefits for their employees. An unacceptable number of New Yorkers  
13 have no health coverage, and many more are severely underinsured. Health  
14 care providers are also affected by inadequate health coverage in New  
15 York state. A large portion of voluntary and public hospitals, health  
16 centers and other providers now experience substantial losses due to the  
17 provision of care that is uncompensated. Individuals often find that  
18 they are deprived of affordable care and choice because of decisions by  
19 health plans guided by the plan's economic needs rather than their  
20 health care needs. To address the fiscal crisis facing the health care  
21 system and the state and to assure New Yorkers can exercise their right

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

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1 to health care, affordable and comprehensive health coverage must be  
2 provided. Pursuant to the state constitution's charge to the legislature  
3 to provide for the health of New Yorkers, this legislation is an enact-  
4 ment of state concern for the purpose of establishing a comprehensive  
5 universal single-payer health care coverage program and a health care  
6 cost control system for the benefit of all residents of the state of New  
7 York.

8 2. It is the intent of the Legislature to create the New York Health  
9 program to provide a universal health plan for every New Yorker, funded  
10 by broad-based revenue based on ability to pay. The state shall work to  
11 obtain waivers relating to Medicaid, Family Health Plus, Child Health  
12 Plus, Medicare, the Patient Protection and Affordable Care Act, and any  
13 other appropriate federal programs, under which federal funds and other  
14 subsidies that would otherwise be paid to New York State and New Yorkers  
15 for health coverage that will be equaled or exceeded by New York Health  
16 will be paid by the federal government to New York State and deposited  
17 in the New York Health trust fund. Under such a waiver, health coverage  
18 under those programs will be replaced and merged into New York Health,  
19 which will operate as a true single-payer program.

20 If such a waiver is not obtained, the state shall use state plan  
21 amendments and seek waivers to maximize, and make as seamless as possi-  
22 ble, the use of federally-matched health programs and federal health  
23 programs in New York Health. Thus, even where other programs such as  
24 Medicaid or Medicare may contribute to paying for care, it is the goal  
25 of this legislation that the coverage will be delivered by New York  
26 Health and, as much as possible, the multiple sources of funding will be  
27 pooled with other New York Health funds and not be apparent to New York  
28 Health members or participating providers. This program will promote  
29 movement away from fee-for-service payment, which tends to reward quan-  
30 tity and requires excessive administrative expense, and towards alter-  
31 nate payment methodologies, such as global or capitated payments to  
32 providers or health care organizations, that promote quality, efficien-  
33 cy, investment in primary and preventive care, and innovation and inte-  
34 gration in the organizing of health care.

35 3. This act does not create any employment benefit, nor does it  
36 require, prohibit, or limit the providing of any employment benefit.

37 4. In order to promote improved quality of, and access to, health care  
38 services and promote improved clinical outcomes, it is the policy of the  
39 state to encourage cooperative, collaborative and integrative arrange-  
40 ments among health care providers who might otherwise be competitors,  
41 under the active supervision of the commissioner of health. It is the  
42 intent of the state to supplant competition with such arrangements and  
43 regulation only to the extent necessary to accomplish the purposes of  
44 this act, and to provide state action immunity under the state and  
45 federal antitrust laws to health care providers, particularly with  
46 respect to their relations with the single-payer New York Health plan  
47 created by this act.

48 S 2. Article 50 and sections 5000, 5001, 5002 and 5003 of the public  
49 health law are renumbered article 80 and sections 8000, 8001, 8002 and  
50 8003, respectively, and a new article 51 is added to read as follows:

51 ARTICLE 51

52 NEW YORK HEALTH

53 SECTION 5100. DEFINITIONS.

54 5101. PROGRAM CREATED.

55 5102. BOARD OF TRUSTEES.

56 5103. ELIGIBILITY AND ENROLLMENT.

1 5104. BENEFITS.

2 5105. HEALTH CARE PROVIDERS; CARE COORDINATION; PAYMENT METHOD-  
3 OLOGIES.

4 5106. HEALTH CARE ORGANIZATIONS.

5 5107. PROGRAM STANDARDS.

6 5108. REGULATIONS.

7 5109. PROVISIONS RELATING TO FEDERAL HEALTH PROGRAMS.

8 5110. ADDITIONAL PROVISIONS.

9 S 5100. DEFINITIONS. AS USED IN THIS ARTICLE, THE FOLLOWING TERMS  
10 SHALL HAVE THE FOLLOWING MEANINGS, UNLESS THE CONTEXT CLEARLY REQUIRES  
11 OTHERWISE:

12 1. "BOARD" MEANS THE BOARD OF TRUSTEES OF THE NEW YORK HEALTH PROGRAM  
13 CREATED BY SECTION FIFTY-ONE HUNDRED TWO OF THIS ARTICLE, AND "TRUSTEE"  
14 MEANS A TRUSTEE OF THE BOARD.

15 2. "CARE COORDINATION" MEANS SERVICES PROVIDED BY A CARE COORDINATOR  
16 UNDER PARAGRAPH (B) OF SUBDIVISION TWO OF SECTION FIFTY-ONE HUNDRED FIVE  
17 OF THIS ARTICLE.

18 3. "CARE COORDINATOR" MEANS AN INDIVIDUAL OR ENTITY APPROVED TO  
19 PROVIDE CARE COORDINATION UNDER PARAGRAPH (B) OF SUBDIVISION TWO OF  
20 SECTION FIFTY-ONE HUNDRED FIVE OF THIS ARTICLE.

21 4. "FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM" MEANS THE MEDICAL ASSIST-  
22 ANCE PROGRAM UNDER TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES  
23 LAW, THE FAMILY HEALTH PLUS PROGRAM UNDER TITLE ELEVEN-D OF ARTICLE FIVE  
24 OF THE SOCIAL SERVICES LAW, AND THE CHILD HEALTH PLUS PROGRAM UNDER  
25 TITLE ONE-A OF ARTICLE TWENTY-FIVE OF THIS CHAPTER.

26 5. "HEALTH CARE ORGANIZATION" MEANS AN ENTITY THAT IS APPROVED BY THE  
27 COMMISSIONER UNDER SECTION FIFTY-ONE HUNDRED SIX OF THIS ARTICLE TO  
28 PROVIDE HEALTH CARE SERVICES TO MEMBERS UNDER THE PROGRAM.

29 6. "HEALTH CARE SERVICE" MEANS ANY HEALTH CARE SERVICE, INCLUDING CARE  
30 COORDINATION, INCLUDED AS A BENEFIT UNDER THE PROGRAM.

31 7. "IMPLEMENTATION PERIOD" MEANS THE PERIOD UNDER SUBDIVISION THREE OF  
32 SECTION FIFTY-ONE HUNDRED ONE OF THIS ARTICLE DURING WHICH THE PROGRAM  
33 WILL BE SUBJECT TO SPECIAL ELIGIBILITY AND FINANCING PROVISIONS UNTIL IT  
34 IS FULLY IMPLEMENTED UNDER THAT SECTION.

35 8. "LONG TERM CARE" MEANS LONG TERM CARE, TREATMENT, MAINTENANCE, OR  
36 SERVICES NOT COVERED UNDER FAMILY HEALTH PLUS OR CHILD HEALTH PLUS, AS  
37 APPROPRIATE, WITH THE EXCEPTION OF SHORT TERM REHABILITATION, AS DEFINED  
38 BY THE COMMISSIONER.

39 9. "MEDICAID" OR "MEDICAL ASSISTANCE" MEANS TITLE ELEVEN OF ARTICLE  
40 FIVE OF THE SOCIAL SERVICES LAW AND THE PROGRAM THEREUNDER. "FAMILY  
41 HEALTH PLUS" MEANS TITLE ELEVEN-D OF ARTICLE FIVE OF THE SOCIAL SERVICES  
42 LAW AND THE PROGRAM THEREUNDER. "CHILD HEALTH PLUS" MEANS TITLE ONE-A OF  
43 ARTICLE TWENTY-FIVE OF THIS CHAPTER AND THE PROGRAM THEREUNDER. "MEDI-  
44 CARE" MEANS TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT AND THE  
45 PROGRAMS THEREUNDER.

46 10. "MEMBER" MEANS AN INDIVIDUAL WHO IS ENROLLED IN THE PROGRAM.

47 11. "NEW YORK HEALTH TRUST FUND" MEANS THE NEW YORK HEALTH TRUST FUND  
48 ESTABLISHED UNDER SECTION EIGHTY-NINE-H OF THE STATE FINANCE LAW.

49 12. "OUT-OF-STATE HEALTH CARE SERVICE" MEANS A HEALTH CARE SERVICE  
50 PROVIDED TO A MEMBER WHILE THE MEMBER IS OUT OF THE STATE AND (A) IT IS  
51 MEDICALLY NECESSARY THAT THE HEALTH CARE SERVICE BE PROVIDED WHILE THE  
52 MEMBER IS OUT OF THE STATE, OR (B) IT IS CLINICALLY APPROPRIATE THAT THE  
53 HEALTH CARE SERVICE BE PROVIDED BY A PARTICULAR HEALTH CARE PROVIDER  
54 LOCATED OUT OF THE STATE RATHER THAN IN THE STATE.

1 13. "PARTICIPATING PROVIDER" MEANS ANY INDIVIDUAL OR ENTITY THAT IS A  
2 HEALTH CARE PROVIDER THAT PROVIDES HEALTH CARE SERVICES TO MEMBERS UNDER  
3 THE PROGRAM, OR A HEALTH CARE ORGANIZATION.

4 14. "PATIENT PROTECTION AND AFFORDABLE CARE ACT" MEANS THE FEDERAL  
5 PATIENT PROTECTION AND AFFORDABLE CARE ACT, PUBLIC LAW 111-148, AS  
6 AMENDED BY THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010,  
7 PUBLIC LAW 111-152, AND ANY REGULATIONS OR GUIDANCE ISSUED THEREUNDER.

8 15. "PERSON" MEANS ANY INDIVIDUAL OR NATURAL PERSON, TRUST, PARTNER-  
9 SHIP, ASSOCIATION, UNINCORPORATED ASSOCIATION, CORPORATION, COMPANY,  
10 LIMITED LIABILITY COMPANY, PROPRIETORSHIP, JOINT VENTURE, FIRM, JOINT  
11 STOCK ASSOCIATION, DEPARTMENT, AGENCY, AUTHORITY, OR OTHER LEGAL ENTITY,  
12 WHETHER FOR-PROFIT, NOT-FOR-PROFIT OR GOVERNMENTAL.

13 16. "PROGRAM" MEANS THE NEW YORK HEALTH PROGRAM CREATED BY SECTION  
14 FIFTY-ONE HUNDRED ONE OF THIS ARTICLE.

15 17. "PRESCRIPTION AND NON-PRESCRIPTION DRUGS" SHALL MEAN PRESCRIPTION  
16 DRUGS AS DEFINED IN SECTION TWO HUNDRED SEVENTY OF THIS CHAPTER, AND  
17 NON-PRESCRIPTION SMOKING CESSATION PRODUCTS OR DEVICES.

18 18. "RESIDENT" MEANS AN INDIVIDUAL WHOSE PRIMARY PLACE OF ABODE IS IN  
19 THE STATE, AS DETERMINED ACCORDING TO REGULATIONS OF THE COMMISSIONER.

20 S 5101. PROGRAM CREATED. 1. THE NEW YORK HEALTH PROGRAM IS HEREBY  
21 CREATED IN THE DEPARTMENT. THE COMMISSIONER SHALL ESTABLISH AND IMPLE-  
22 MENT THE PROGRAM UNDER THIS ARTICLE. THE PROGRAM SHALL PROVIDE COMPRE-  
23 HENSIVE HEALTH COVERAGE TO EVERY RESIDENT WHO ENROLLS IN THE PROGRAM.

24 2. THE COMMISSIONER SHALL, TO THE MAXIMUM EXTENT POSSIBLE, ORGANIZE,  
25 ADMINISTER AND MARKET THE PROGRAM AND SERVICES AS A SINGLE PROGRAM UNDER  
26 THE NAME "NEW YORK HEALTH" OR SUCH OTHER NAME AS THE COMMISSIONER SHALL  
27 DETERMINE, REGARDLESS OF UNDER WHICH LAW OR SOURCE THE DEFINITION OF A  
28 BENEFIT IS FOUND INCLUDING (ON A VOLUNTARY BASIS) RETIREE HEALTH BENE-  
29 FITS. IN IMPLEMENTING THIS SUBDIVISION, THE COMMISSIONER SHALL AVOID  
30 JEOPARDIZING FEDERAL FINANCIAL PARTICIPATION IN THESE PROGRAMS AND SHALL  
31 TAKE CARE TO PROMOTE PUBLIC UNDERSTANDING AND AWARENESS OF AVAILABLE  
32 BENEFITS AND PROGRAMS.

33 3. THE COMMISSIONER SHALL DETERMINE WHEN INDIVIDUALS MAY BEGIN ENROLL-  
34 ING IN THE PROGRAM. THERE SHALL BE AN IMPLEMENTATION PERIOD, WHICH SHALL  
35 BEGIN ON THE DATE THAT INDIVIDUALS MAY BEGIN ENROLLING IN THE PROGRAM  
36 AND SHALL END AS DETERMINED BY THE COMMISSIONER.

37 4. AN INSURER AUTHORIZED TO PROVIDE COVERAGE PURSUANT TO THE INSURANCE  
38 LAW OR A HEALTH MAINTENANCE ORGANIZATION CERTIFIED UNDER THIS CHAPTER  
39 MAY, IF OTHERWISE AUTHORIZED, OFFER BENEFITS THAT DO NOT DUPLICATE  
40 COVERAGE OFFERED TO AN INDIVIDUAL UNDER THE PROGRAM, BUT MAY NOT OFFER  
41 BENEFITS THAT DUPLICATE COVERAGE OFFERED TO AN INDIVIDUAL UNDER THE  
42 PROGRAM. PROVIDED, HOWEVER, THAT THIS SUBDIVISION SHALL NOT PROHIBIT (A)  
43 THE OFFERING OF ANY BENEFITS TO OR FOR INDIVIDUALS, INCLUDING THEIR  
44 FAMILIES, WHO ARE EMPLOYED OR SELF-EMPLOYED IN THE STATE BUT WHO ARE NOT  
45 RESIDENTS OF THE STATE, OR (B) THE OFFERING OF BENEFITS DURING THE  
46 IMPLEMENTATION PERIOD TO INDIVIDUALS WHO ENROLLED AS MEMBERS OF THE  
47 PROGRAM, OR (C) THE OFFERING OF RETIREE HEALTH BENEFITS.

48 5. A COLLEGE, UNIVERSITY OR OTHER INSTITUTION OF HIGHER EDUCATION IN  
49 THE STATE MAY PURCHASE COVERAGE UNDER THE PROGRAM FOR ANY STUDENT, OR  
50 STUDENT'S DEPENDENT, WHO IS NOT A RESIDENT OF THE STATE.

51 S 5102. BOARD OF TRUSTEES. 1. THE NEW YORK HEALTH BOARD OF TRUSTEES IS  
52 HEREBY CREATED IN THE DEPARTMENT. THE BOARD OF TRUSTEES SHALL, AT THE  
53 REQUEST OF THE COMMISSIONER, CONSIDER ANY MATTER TO EFFECTUATE THE  
54 PROVISIONS AND PURPOSES OF THIS ARTICLE, AND MAY ADVISE THE COMMISSIONER  
55 THEREON; AND IT MAY, FROM TIME TO TIME, SUBMIT TO THE COMMISSIONER ANY  
56 RECOMMENDATIONS TO EFFECTUATE THE PROVISIONS AND PURPOSES OF THIS ARTI-

CLE. THE COMMISSIONER MAY PROPOSE REGULATIONS UNDER THIS ARTICLE AND AMENDMENTS THERETO FOR CONSIDERATION BY THE BOARD. THE BOARD OF TRUSTEES SHALL HAVE NO EXECUTIVE, ADMINISTRATIVE OR APPOINTIVE DUTIES EXCEPT AS OTHERWISE PROVIDED BY LAW. THE BOARD OF TRUSTEES SHALL HAVE POWER TO ESTABLISH, AND FROM TIME TO TIME, AMEND REGULATIONS TO EFFECTUATE THE PROVISIONS AND PURPOSES OF THIS ARTICLE, SUBJECT TO APPROVAL BY THE COMMISSIONER.

2. THE BOARD SHALL BE COMPOSED OF:

(A) THE COMMISSIONER, THE SUPERINTENDENT OF FINANCIAL SERVICES, AND THE DIRECTOR OF THE BUDGET, OR THEIR DESIGNEES, AS EX OFFICIO MEMBERS;

(B) SEVENTEEN TRUSTEES APPOINTED BY THE GOVERNOR;

(I) FIVE OF WHOM SHALL BE REPRESENTATIVES OF HEALTH CARE CONSUMER ADVOCACY ORGANIZATIONS WHICH HAVE A STATEWIDE OR REGIONAL CONSTITUENCY, WHO HAVE BEEN INVOLVED IN ACTIVITIES RELATED TO HEALTH CARE CONSUMER ADVOCACY, INCLUDING ISSUES OF INTEREST TO LOW- AND MODERATE-INCOME INDIVIDUALS;

(II) TWO OF WHOM SHALL BE REPRESENTATIVES OF PROFESSIONAL ORGANIZATIONS REPRESENTING PHYSICIANS;

(III) TWO OF WHOM SHALL BE REPRESENTATIVES OF PROFESSIONAL ORGANIZATIONS REPRESENTING LICENSED OR REGISTERED HEALTH CARE PROFESSIONALS OTHER THAN PHYSICIANS;

(IV) THREE OF WHOM SHALL BE REPRESENTATIVES OF HOSPITALS, ONE OF WHOM SHALL BE A REPRESENTATIVE OF PUBLIC HOSPITALS;

(V) ONE OF WHOM SHALL BE REPRESENTATIVE OF COMMUNITY HEALTH CENTERS;

(VI) TWO OF WHOM SHALL BE REPRESENTATIVES OF HEALTH CARE ORGANIZATIONS; AND

(VIII) TWO OF WHOM SHALL BE REPRESENTATIVES OF ORGANIZED LABOR;

(C) THREE TRUSTEES APPOINTED BY THE SPEAKER OF THE ASSEMBLY; THREE TRUSTEES APPOINTED BY THE TEMPORARY PRESIDENT OF THE SENATE; ONE TRUSTEE APPOINTED BY THE MINORITY LEADER OF THE ASSEMBLY; AND ONE TRUSTEE APPOINTED BY THE MINORITY LEADER OF THE SENATE.

AFTER THE END OF THE IMPLEMENTATION PERIOD, NO PERSON SHALL BE A TRUSTEE UNLESS HE OR SHE IS A MEMBER OF THE PROGRAM, EXCEPT THE EX OFFICIO TRUSTEES. EACH TRUSTEE SHALL SERVE AT THE PLEASURE OF THE APPOINTING OFFICER, EXCEPT THE EX OFFICIO TRUSTEES.

3. THE CHAIR OF THE BOARD SHALL BE APPOINTED, AND MAY BE REMOVED AS CHAIR, BY THE GOVERNOR FROM AMONG THE TRUSTEES. THE BOARD SHALL MEET AT LEAST FOUR TIMES EACH CALENDAR YEAR. MEETINGS SHALL BE HELD UPON THE CALL OF THE CHAIR AND AS PROVIDED BY THE BOARD. A MAJORITY OF THE APPOINTED TRUSTEES SHALL BE A QUORUM OF THE BOARD, AND THE AFFIRMATIVE VOTE OF A MAJORITY OF THE TRUSTEES VOTING, BUT NOT LESS THAN TEN, SHALL BE NECESSARY FOR ANY ACTION TO BE TAKEN BY THE BOARD. THE BOARD MAY ESTABLISH AN EXECUTIVE COMMITTEE TO EXERCISE ANY POWERS OR DUTIES OF THE BOARD AS IT MAY PROVIDE, AND OTHER COMMITTEES TO ASSIST THE BOARD OR THE EXECUTIVE COMMITTEE. THE CHAIR OF THE BOARD SHALL CHAIR THE EXECUTIVE COMMITTEE AND SHALL APPOINT THE CHAIR AND MEMBERS OF ALL OTHER COMMITTEES. THE BOARD OF TRUSTEES MAY APPOINT ONE OR MORE ADVISORY COMMITTEES. MEMBERS OF ADVISORY COMMITTEES NEED NOT BE MEMBERS OF THE BOARD OF TRUSTEES.

4. TRUSTEES SHALL SERVE WITHOUT COMPENSATION BUT SHALL BE REIMBURSED FOR THEIR NECESSARY AND ACTUAL EXPENSES INCURRED WHILE ENGAGED IN THE BUSINESS OF THE BOARD.

5. NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, NO OFFICER OR EMPLOYEE OF THE STATE OR ANY LOCAL GOVERNMENT SHALL FORFEIT OR BE DEEMED TO HAVE FORFEITED HIS OR HER OFFICE OR EMPLOYMENT BY REASON OF BEING A TRUSTEE.

1 6. THE BOARD AND ITS COMMITTEES AND ADVISORY COMMITTEES MAY REQUEST  
2 AND RECEIVE THE ASSISTANCE OF THE DEPARTMENT AND ANY OTHER STATE OR  
3 LOCAL GOVERNMENTAL ENTITY IN EXERCISING ITS POWERS AND DUTIES.

4 7. NO LATER THAN FIVE YEARS AFTER THE EFFECTIVE DATE OF THIS ARTICLE:

5 (A) THE BOARD SHALL DEVELOP A PROPOSAL, CONSISTENT WITH THE PRINCIPLES  
6 OF THIS ARTICLE, FOR PROVISION BY THE PROGRAM OF LONG-TERM CARE COVER-  
7 AGE, INCLUDING THE DEVELOPMENT OF A PROPOSAL, CONSISTENT WITH THE PRIN-  
8 CIPLES OF THIS ARTICLE, FOR ITS FUNDING. IN DEVELOPING THE PROPOSAL,  
9 THE BOARD SHALL CONSULT WITH AN ADVISORY COMMITTEE, APPOINTED BY THE  
10 CHAIR OF THE BOARD, INCLUDING REPRESENTATIVES OF CONSUMERS AND POTENTIAL  
11 CONSUMERS OF LONG-TERM CARE, PROVIDERS OF LONG-TERM CARE, LABOR, AND  
12 OTHER INTERESTED PARTIES. THE BOARD SHALL PRESENT ITS PROPOSAL TO THE  
13 GOVERNOR AND THE LEGISLATURE.

14 (B) THE BOARD SHALL DEVELOP PROPOSALS FOR: (I) INCORPORATING RETIREE  
15 HEALTH BENEFITS INTO NEW YORK HEALTH; AND (II) ACCOMMODATING EMPLOYER  
16 RETIREE HEALTH BENEFITS FOR PEOPLE WHO HAVE BEEN MEMBERS OF NEW YORK  
17 HEALTH BUT LIVE AS RETIREES OUT OF THE STATE.

18 S 5103. ELIGIBILITY AND ENROLLMENT. 1. EVERY RESIDENT OF THE STATE  
19 SHALL BE ELIGIBLE AND ENTITLED TO ENROLL AS A MEMBER UNDER THE PROGRAM.

20 2. NO MEMBER SHALL BE REQUIRED TO PAY ANY PREMIUM OR OTHER CHARGE FOR  
21 ENROLLING IN OR BEING A MEMBER UNDER THE PROGRAM.

22 S 5104. BENEFITS. 1. THE PROGRAM SHALL PROVIDE COMPREHENSIVE HEALTH  
23 COVERAGE TO EVERY MEMBER, WHICH SHALL INCLUDE ALL HEALTH CARE SERVICES  
24 REQUIRED TO BE COVERED UNDER ANY OF THE FOLLOWING, WITHOUT REGARD TO  
25 WHETHER THE MEMBER WOULD OTHERWISE BE ELIGIBLE FOR OR COVERED BY THE  
26 PROGRAM OR SOURCE REFERRED TO:

27 (A) FAMILY HEALTH PLUS;

28 (B) FOR EVERY MEMBER UNDER THE AGE OF TWENTY-ONE, CHILD HEALTH PLUS;

29 (C) MEDICAID;

30 (D) MEDICARE;

31 (E) ARTICLE FORTY-FOUR OF THIS CHAPTER OR ARTICLE THIRTY-TWO OR  
32 FORTY-THREE OF THE INSURANCE LAW;

33 (F) ARTICLE ELEVEN OF THE CIVIL SERVICE LAW, AS OF THE DATE ONE YEAR  
34 BEFORE THE BEGINNING OF THE IMPLEMENTATION PERIOD;

35 (G) ANY ADDITIONAL HEALTH CARE SERVICE AUTHORIZED TO BE ADDED TO THE  
36 PROGRAM'S BENEFITS BY THE PROGRAM; AND

37 (H) PROVIDED THAT NONE OF THE ABOVE SHALL INCLUDE LONG TERM CARE,  
38 UNTIL A PROPOSAL UNDER PARAGRAPH (A) OF SUBDIVISION SEVEN OF SECTION  
39 FIFTY-ONE HUNDRED TWO OF THIS ARTICLE IS ENACTED INTO LAW.

40 2. NO MEMBER SHALL BE REQUIRED TO PAY ANY DEDUCTIBLE, CO-PAYMENT OR  
41 CO-INSURANCE UNDER THE PROGRAM.

42 3. THE PROGRAM SHALL PROVIDE FOR PAYMENT UNDER THE PROGRAM FOR EMER-  
43 GENCY AND TEMPORARY HEALTH CARE SERVICES PROVIDED TO MEMBERS OR INDIVID-  
44 UALS ENTITLED TO BECOME MEMBERS WHO HAVE NOT HAD A REASONABLE OPPORTU-  
45 NITY TO BECOME A MEMBER OR TO ENROLL WITH A CARE COORDINATOR.

46 S 5105. HEALTH CARE PROVIDERS; CARE COORDINATION; PAYMENT METHODOL-  
47 OGIES. 1. CHOICE OF HEALTH CARE PROVIDER. (A) ANY HEALTH CARE PROVIDER  
48 QUALIFIED TO PARTICIPATE UNDER THIS SECTION MAY PROVIDE HEALTH CARE  
49 SERVICES UNDER THE PROGRAM, PROVIDED THAT THE HEALTH CARE PROVIDER IS  
50 OTHERWISE LEGALLY AUTHORIZED TO PERFORM THE HEALTH CARE SERVICE FOR THE  
51 INDIVIDUAL AND UNDER THE CIRCUMSTANCES INVOLVED.

52 (B) A MEMBER MAY CHOOSE TO RECEIVE HEALTH CARE SERVICES UNDER THE  
53 PROGRAM FROM ANY PARTICIPATING PROVIDER, CONSISTENT WITH PROVISIONS OF  
54 THIS ARTICLE RELATING TO CARE COORDINATION AND HEALTH CARE ORGANIZA-  
55 TIONS, THE WILLINGNESS OR AVAILABILITY OF THE PROVIDER (SUBJECT TO

PROVISIONS OF THIS ARTICLE RELATING TO DISCRIMINATION), AND THE APPROPRIATE CLINICALLY-RELEVANT CIRCUMSTANCES.

2. CARE COORDINATION. (A) HEALTH CARE SERVICES PROVIDED TO A MEMBER SHALL NOT BE SUBJECT TO PAYMENT UNDER THE PROGRAM UNLESS THE MEMBER IS ENROLLED WITH A CARE COORDINATOR AT THE TIME THE HEALTH CARE SERVICE IS PROVIDED, EXCEPT WHERE PROVIDED UNDER SUBDIVISION THREE OF SECTION FIFTY-ONE HUNDRED FOUR OF THIS ARTICLE. EVERY MEMBER SHALL ENROLL WITH A CARE COORDINATOR THAT AGREES TO PROVIDE CARE COORDINATION TO THE MEMBER PRIOR TO RECEIVING HEALTH CARE SERVICES TO BE PAID FOR UNDER THE PROGRAM. THE MEMBER SHALL REMAIN ENROLLED WITH THAT CARE COORDINATOR UNTIL THE MEMBER BECOMES ENROLLED WITH A DIFFERENT CARE COORDINATOR OR CEASES TO BE A MEMBER. THE COMMISSIONER SHALL PROVIDE, BY REGULATION, THAT MEMBERS HAVE THE RIGHT TO CHANGE THEIR CARE COORDINATOR ON TERMS AT LEAST AS PERMISSIVE AS THE PROVISIONS OF SECTION THREE HUNDRED SIXTY-FOUR-J OF THE SOCIAL SERVICES LAW RELATING TO AN INDIVIDUAL CHANGING HIS OR HER PRIMARY CARE PROVIDER OR MANAGED CARE PROVIDER.

(B) CARE COORDINATION SHALL BE PROVIDED TO THE MEMBER BY THE MEMBER'S CARE COORDINATOR. A CARE COORDINATOR MAY EMPLOY OR UTILIZE THE SERVICES OF OTHER INDIVIDUALS OR ENTITIES TO ASSIST IN PROVIDING CARE COORDINATION FOR THE MEMBER, CONSISTENT WITH REGULATIONS OF THE COMMISSIONER. CARE COORDINATION SHALL INCLUDE, BUT NOT BE LIMITED TO, MANAGING, REFERRING TO, LOCATING, COORDINATING, AND MONITORING HEALTH CARE SERVICES FOR THE MEMBER TO ASSURE THAT ALL MEDICALLY NECESSARY HEALTH CARE SERVICES ARE MADE AVAILABLE TO AND ARE EFFECTIVELY USED BY THE MEMBER IN A TIMELY MANNER, CONSISTENT WITH PATIENT AUTONOMY. CARE COORDINATION IS NOT A REQUIREMENT FOR PRIOR AUTHORIZATION FOR HEALTH CARE SERVICES AND REFERRAL SHALL NOT BE REQUIRED FOR A MEMBER TO RECEIVE A HEALTH CARE SERVICE. HOWEVER: (I) A HEALTH CARE ORGANIZATION MAY ESTABLISH RULES RELATING TO CARE COORDINATION FOR MEMBERS IN THE HEALTH CARE ORGANIZATION, DIFFERENT FROM THIS SUBDIVISION BUT OTHERWISE CONSISTENT WITH THIS ARTICLE AND OTHER APPLICABLE LAWS; AND (II) NOTHING IN THIS SUBDIVISION SHALL AUTHORIZE ANY INDIVIDUAL TO ENGAGE IN ANY ACT IN VIOLATION OF TITLE EIGHT OF THE EDUCATION LAW.

(C) WHERE A MEMBER RECEIVES CHRONIC MENTAL HEALTH CARE SERVICES, AT THE OPTION OF THE MEMBER, THE MEMBER MAY ENROLL WITH A CARE COORDINATOR FOR HIS OR HER MENTAL HEALTH CARE SERVICES AND ANOTHER CARE COORDINATOR APPROVED FOR HIS OR HER OTHER HEALTH CARE SERVICES, CONSISTENT WITH STANDARDS ESTABLISHED BY THE COMMISSIONER IN CONSULTATION WITH THE COMMISSIONER OF MENTAL HEALTH. IN SUCH A CASE, THE TWO CARE COORDINATORS SHALL WORK IN CLOSE CONSULTATION WITH EACH OTHER.

(D) A CARE COORDINATOR MAY BE AN INDIVIDUAL OR ENTITY THAT IS APPROVED BY THE PROGRAM THAT IS:

(I) A HEALTH CARE PRACTITIONER WHO IS: (A) THE MEMBER'S PRIMARY CARE PRACTITIONER; (B) AT THE OPTION OF A FEMALE MEMBER, THE MEMBER'S PROVIDER OF PRIMARY GYNECOLOGICAL CARE; OR (C) AT THE OPTION OF A MEMBER WHO HAS A CHRONIC CONDITION THAT REQUIRES SPECIALTY CARE, A SPECIALIST HEALTH CARE PRACTITIONER WHO REGULARLY AND CONTINUALLY PROVIDES TREATMENT FOR THAT CONDITION TO THE MEMBER;

(II) AN ENTITY LICENSED UNDER ARTICLE TWENTY-EIGHT OF THIS CHAPTER OR CERTIFIED UNDER ARTICLE THIRTY-SIX OF THIS CHAPTER, A MANAGED LONG TERM CARE PLAN UNDER SECTION FORTY-FOUR HUNDRED THREE-F OF THIS CHAPTER OR OTHER PROGRAM MODEL UNDER PARAGRAPH (B) OF SUBDIVISION SEVEN OF SUCH SECTION, OR, WITH RESPECT TO A MEMBER WHO RECEIVES CHRONIC MENTAL HEALTH CARE SERVICES, AN ENTITY LICENSED UNDER ARTICLE THIRTY-ONE OF THE MENTAL HYGIENE LAW OR OTHER ENTITY APPROVED BY THE COMMISSIONER IN CONSULTATION WITH THE COMMISSIONER OF MENTAL HEALTH;

1 (III) A HEALTH CARE ORGANIZATION;

2 (IV) A TAFT-HARTLEY FUND, WITH RESPECT TO ITS MEMBERS AND THEIR FAMILY  
3 MEMBERS; PROVIDED THAT THIS PROVISION SHALL NOT PRECLUDE A TAFT-HARTLEY  
4 FUND FROM BECOMING A CARE COORDINATOR UNDER SUBPARAGRAPH (V) OF THIS  
5 PARAGRAPH OR A HEALTH CARE ORGANIZATION UNDER SECTION FIFTY-ONE HUNDRED  
6 SIX OF THIS ARTICLE; OR

7 (V) ANY NOT-FOR-PROFIT OR GOVERNMENTAL ENTITY APPROVED BY THE PROGRAM.

8 (E) THE COMMISSIONER SHALL DEVELOP AND IMPLEMENT PROCEDURES AND STAND-  
9 ARDS FOR AN INDIVIDUAL OR ENTITY TO BE APPROVED TO BE A CARE COORDINATOR  
10 IN THE PROGRAM, INCLUDING BUT NOT LIMITED TO PROCEDURES AND STANDARDS  
11 RELATING TO THE REVOCATION, SUSPENSION, LIMITATION, OR ANNULMENT OF  
12 APPROVAL ON A DETERMINATION THAT THE INDIVIDUAL OR ENTITY IS INCOMPETENT  
13 TO BE A CARE COORDINATOR OR HAS EXHIBITED A COURSE OF CONDUCT WHICH IS  
14 EITHER INCONSISTENT WITH PROGRAM STANDARDS AND REGULATIONS OR WHICH  
15 EXHIBITS AN UNWILLINGNESS TO MEET SUCH STANDARDS AND REGULATIONS, OR IS  
16 A POTENTIAL THREAT TO THE PUBLIC HEALTH OR SAFETY. SUCH PROCEDURES AND  
17 STANDARDS SHALL NOT LIMIT APPROVAL TO BE A CARE COORDINATOR IN THE  
18 PROGRAM FOR ECONOMIC PURPOSES AND SHALL BE CONSISTENT WITH GOOD PROFES-  
19 SIONAL PRACTICE. IN DEVELOPING THE PROCEDURES AND STANDARDS, THE COMMIS-  
20 SIONER SHALL: (I) CONSIDER EXISTING STANDARDS DEVELOPED BY NATIONAL  
21 ACCREDITING AND PROFESSIONAL ORGANIZATIONS; AND (II) CONSULT WITH  
22 NATIONAL AND LOCAL ORGANIZATIONS WORKING ON CARE COORDINATION OR SIMILAR  
23 MODELS, INCLUDING HEALTH CARE PRACTITIONERS, HOSPITALS, CLINICS, AND  
24 CONSUMERS AND THEIR REPRESENTATIVES. WHEN DEVELOPING AND IMPLEMENTING  
25 STANDARDS OF APPROVAL OF CARE COORDINATORS FOR INDIVIDUALS RECEIVING  
26 CHRONIC MENTAL HEALTH CARE SERVICES, THE COMMISSIONER SHALL CONSULT WITH  
27 THE COMMISSIONER OF MENTAL HEALTH. AN INDIVIDUAL OR ENTITY MAY NOT BE A  
28 CARE COORDINATOR UNLESS THE SERVICES INCLUDED IN CARE COORDINATION ARE  
29 WITHIN THE INDIVIDUAL'S PROFESSIONAL SCOPE OF PRACTICE OR THE ENTITY'S  
30 LEGAL AUTHORITY.

31 (F) TO MAINTAIN APPROVAL UNDER THE PROGRAM, A CARE COORDINATOR MUST:

32 (I) RENEW ITS STATUS AT A FREQUENCY DETERMINED BY THE COMMISSIONER; AND  
33 (II) PROVIDE DATA TO THE DEPARTMENT AS REQUIRED BY THE COMMISSIONER TO  
34 ENABLE THE COMMISSIONER TO EVALUATE THE IMPACT OF CARE COORDINATORS ON  
35 QUALITY, OUTCOMES AND COST.

36 3. HEALTH CARE PROVIDERS. (A) THE COMMISSIONER SHALL ESTABLISH AND  
37 MAINTAIN PROCEDURES AND STANDARDS FOR HEALTH CARE PROVIDERS TO BE QUALI-  
38 FIED TO PARTICIPATE IN THE PROGRAM, INCLUDING BUT NOT LIMITED TO PROCE-  
39 DURES AND STANDARDS RELATING TO THE REVOCATION, SUSPENSION, LIMITATION,  
40 OR ANNULMENT OF QUALIFICATION TO PARTICIPATE ON A DETERMINATION THAT THE  
41 HEALTH CARE PROVIDER IS AN INCOMPETENT PROVIDER OF SPECIFIC HEALTH CARE  
42 SERVICES OR HAS EXHIBITED A COURSE OF CONDUCT WHICH IS EITHER INCONSIST-  
43 ENT WITH PROGRAM STANDARDS AND REGULATIONS OR WHICH EXHIBITS AN UNWILL-  
44 INGNESS TO MEET SUCH STANDARDS AND REGULATIONS, OR IS A POTENTIAL THREAT  
45 TO THE PUBLIC HEALTH OR SAFETY. SUCH PROCEDURES AND STANDARDS SHALL NOT  
46 LIMIT HEALTH CARE PROVIDER PARTICIPATION IN THE PROGRAM FOR ECONOMIC  
47 PURPOSES AND SHALL BE CONSISTENT WITH GOOD PROFESSIONAL PRACTICE. ANY  
48 HEALTH CARE PROVIDER WHO IS QUALIFIED TO PARTICIPATE UNDER MEDICAID,  
49 FAMILY HEALTH PLUS, CHILD HEALTH PLUS OR MEDICARE SHALL BE DEEMED TO BE  
50 QUALIFIED TO PARTICIPATE IN THE PROGRAM, AND ANY HEALTH CARE PROVIDER'S  
51 REVOCATION, SUSPENSION, LIMITATION, OR ANNULMENT OF QUALIFICATION TO  
52 PARTICIPATE IN ANY OF THOSE PROGRAMS SHALL APPLY TO THE HEALTH CARE  
53 PROVIDER'S QUALIFICATION TO PARTICIPATE IN THE PROGRAM; PROVIDED THAT A  
54 HEALTH CARE PROVIDER QUALIFIED UNDER THIS SENTENCE SHALL FOLLOW THE  
55 PROCEDURES TO BECOME QUALIFIED UNDER THE PROGRAM BY THE END OF THE  
56 IMPLEMENTATION PERIOD.



(B) THE COMMISSIONER SHALL ESTABLISH AND MAINTAIN PROCEDURES AND STANDARDS FOR RECOGNIZING HEALTH CARE PROVIDERS LOCATED OUT OF THE STATE FOR PURPOSES OF PROVIDING COVERAGE UNDER THE PROGRAM FOR OUT-OF-STATE HEALTH CARE SERVICES.

4. PAYMENT FOR HEALTH CARE SERVICES. (A) HEALTH CARE SERVICES PROVIDED TO MEMBERS UNDER THE PROGRAM SHALL BE PAID FOR ON A FEE-FOR-SERVICE BASIS, EXCEPT FOR CARE COORDINATION. HOWEVER, THE COMMISSIONER MAY ESTABLISH BY REGULATION OTHER PAYMENT METHODOLOGIES FOR HEALTH CARE SERVICES AND CARE COORDINATION PROVIDED TO MEMBERS UNDER THE PROGRAM BY PARTICIPATING PROVIDERS, CARE COORDINATORS, AND HEALTH CARE ORGANIZATIONS. THERE MAY BE A VARIETY OF DIFFERENT PAYMENT METHODOLOGIES, INCLUDING THOSE ESTABLISHED ON A DEMONSTRATION BASIS. ALL PAYMENT RATES UNDER THE PROGRAM SHALL BE REASONABLE AND REASONABLY RELATED TO THE COST OF EFFICIENTLY PROVIDING THE HEALTH CARE SERVICE AND ASSURING AN ADEQUATE AND ACCESSIBLE SUPPLY OF HEALTH CARE SERVICE.

(B) THE PROGRAM SHALL ENGAGE IN GOOD FAITH NEGOTIATIONS WITH HEALTH CARE PROVIDERS' REPRESENTATIVES UNDER TITLE III OF ARTICLE FORTY-NINE OF THIS CHAPTER, INCLUDING, BUT NOT LIMITED TO, IN RELATION TO RATES OF PAYMENT AND PAYMENT METHODOLOGIES.

(C) NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, PAYMENT FOR DRUGS PROVIDED BY PHARMACIES UNDER THE PROGRAM SHALL BE MADE PURSUANT TO ARTICLE TWO-A OF THIS CHAPTER AND SUBDIVISION FOUR OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THE SOCIAL SERVICES LAW. HOWEVER, THE PROGRAM SHALL PROVIDE FOR PAYMENT FOR PRESCRIPTION DRUGS UNDER SECTION 340B OF THE FEDERAL PUBLIC SERVICE ACT WHERE APPLICABLE. PAYMENT FOR PRESCRIPTION DRUGS PROVIDED BY HEALTH CARE PROVIDERS OTHER THAN PHARMACIES SHALL BE PURSUANT TO OTHER PROVISIONS OF THIS ARTICLE.

(D) PAYMENT FOR HEALTH CARE SERVICES ESTABLISHED UNDER THIS ARTICLE SHALL BE CONSIDERED PAYMENT IN FULL. A PARTICIPATING PROVIDER SHALL NOT CHARGE ANY RATE IN EXCESS OF THE PAYMENT ESTABLISHED UNDER THIS ARTICLE FOR ANY HEALTH CARE SERVICE UNDER THE PROGRAM PROVIDED TO A MEMBER AND SHALL NOT SOLICIT OR ACCEPT PAYMENT FROM ANY MEMBER OR THIRD PARTY FOR ANY SUCH SERVICE EXCEPT AS PROVIDED UNDER THIS ARTICLE. HOWEVER, THIS PARAGRAPH SHALL NOT PRECLUDE THE PROGRAM FROM ACTING AS A PRIMARY OR SECONDARY PAYER IN CONJUNCTION WITH ANOTHER THIRD-PARTY PAYER WHERE PERMITTED UNDER THIS ARTICLE.

(E) THE PROGRAM MAY PROVIDE IN PAYMENT METHODOLOGIES FOR PAYMENT FOR CAPITAL RELATED EXPENSES FOR SPECIFICALLY IDENTIFIED CAPITAL EXPENDITURES INCURRED BY NOT-FOR-PROFIT OR GOVERNMENTAL ENTITIES CERTIFIED UNDER ARTICLE TWENTY-EIGHT OF THIS CHAPTER. ANY CAPITAL RELATED EXPENSE GENERATED BY A CAPITAL EXPENDITURE THAT REQUIRES OR REQUIRED APPROVAL UNDER ARTICLE TWENTY-EIGHT OF THIS CHAPTER MUST HAVE RECEIVED THAT APPROVAL FOR THE CAPITAL RELATED EXPENSE TO BE PAID FOR UNDER THE PROGRAM.

(F) THE COMMISSIONER SHALL PROVIDE BY REGULATION FOR PAYMENT METHODOLOGIES AND PROCEDURES FOR PAYING FOR OUT-OF-STATE HEALTH CARE SERVICES.

5. (A) FOR PURPOSES OF THIS SUBDIVISION, "INCOME-ELIGIBLE MEMBER" MEANS A MEMBER WHO IS ENROLLED IN A FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM AND (I) THERE IS FEDERAL FINANCIAL PARTICIPATION IN THE INDIVIDUAL'S HEALTH COVERAGE, OR (II) THE MEMBER IS ELIGIBLE TO ENROLL IN THE FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM BY REASON OF INCOME, AGE, AND RESOURCES (WHERE APPLICABLE) UNDER STATE LAW IN EFFECT ON THE EFFECTIVE DATE OF THIS SECTION, BUT THERE IS NO FEDERAL FINANCIAL PARTICIPATION IN THE INDIVIDUAL'S HEALTH COVERAGE. A PERSON WHO IS ELIGIBLE TO ENROLL IN A FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM SOLELY BY REASON OF SECTION

THREE HUNDRED SIXTY-NINE-FF OF THE SOCIAL SERVICES LAW (EMPLOYER PART-  
NERSHIPS FOR FAMILY HEALTH PLUS) IS NOT AN INCOME-ELIGIBLE MEMBER.

(B) THE PROGRAM, WITH RESPECT TO INCOME-ELIGIBLE MEMBERS, SHALL BE  
CONSIDERED A FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM OR GOVERNMENT PAYOR  
UNDER ARTICLE TWENTY-EIGHT OF THIS CHAPTER WITH RESPECT TO THE FOLLOWING  
PROVISIONS, AND WITH RESPECT TO THOSE MEMBERS WHO ARE NOT INCOME-ELIGI-  
BLE MEMBERS, SHALL NOT BE CONSIDERED A FEDERALLY-MATCHED PUBLIC HEALTH  
PROGRAM OR GOVERNMENTAL PAYOR UNDER ARTICLE TWENTY-EIGHT OF THIS CHAPTER  
WITH RESPECT TO THE FOLLOWING PROVISIONS:

(I) PATIENT SERVICES PAYMENTS IN ACCORDANCE WITH SECTION TWENTY-EIGHT  
HUNDRED SEVEN-J OF THIS CHAPTER;

(II) PROFESSIONAL EDUCATION POOL FUNDING UNDER SECTION TWENTY-EIGHT  
HUNDRED SEVEN-S OF THIS CHAPTER; OR

(III) ASSESSMENTS ON COVERED LIVES UNDER SECTION TWENTY-EIGHT HUNDRED  
SEVEN-T OF THIS CHAPTER.

S 5106. HEALTH CARE ORGANIZATIONS. 1. A MEMBER MAY CHOOSE TO ENROLL  
WITH AND RECEIVE HEALTH CARE SERVICES UNDER THE PROGRAM FROM A HEALTH  
CARE ORGANIZATION.

2. A HEALTH CARE ORGANIZATION SHALL BE A NOT-FOR-PROFIT OR GOVERN-  
MENTAL ENTITY THAT IS APPROVED BY THE COMMISSIONER THAT IS:

(A) AN ACCOUNTABLE CARE ORGANIZATION UNDER ARTICLE TWENTY-NINE-E OF  
THIS CHAPTER; OR

(B) A TAFT-HARTLEY FUND (I) WITH RESPECT TO ITS MEMBERS AND THEIR  
FAMILY MEMBERS, AND (II) IF ALLOWED BY APPLICABLE LAW AND APPROVED BY  
THE COMMISSIONER, FOR OTHER MEMBERS OF THE PROGRAM; PROVIDED THAT THE  
COMMISSIONER SHALL PROVIDE BY REGULATION THAT WHERE A TAFT-HARTLEY FUND  
IS ACTING UNDER THIS SUBPARAGRAPH THERE ARE PROTECTIONS FOR HEALTH CARE  
PROVIDERS AND PATIENTS COMPARABLE TO THOSE APPLICABLE TO ACCOUNTABLE  
CARE ORGANIZATIONS.

3. A HEALTH CARE ORGANIZATION MAY BE RESPONSIBLE FOR ALL OR PART OF  
THE HEALTH CARE SERVICES TO WHICH ITS MEMBERS ARE ENTITLED UNDER THE  
PROGRAM, CONSISTENT WITH THE TERMS OF ITS APPROVAL BY THE COMMISSIONER.

4. (A) THE COMMISSIONER SHALL DEVELOP AND IMPLEMENT PROCEDURES AND  
STANDARDS FOR AN ENTITY TO BE APPROVED TO BE A HEALTH CARE ORGANIZATION  
IN THE PROGRAM, INCLUDING BUT NOT LIMITED TO PROCEDURES AND STANDARDS  
RELATING TO THE REVOCATION, SUSPENSION, LIMITATION, OR ANNULMENT OF  
APPROVAL ON A DETERMINATION THAT THE ENTITY IS INCOMPETENT TO BE A  
HEALTH CARE ORGANIZATION OR HAS EXHIBITED A COURSE OF CONDUCT WHICH IS  
EITHER INCONSISTENT WITH PROGRAM STANDARDS AND REGULATIONS OR WHICH  
EXHIBITS AN UNWILLINGNESS TO MEET SUCH STANDARDS AND REGULATIONS, OR IS  
A POTENTIAL THREAT TO THE PUBLIC HEALTH OR SAFETY. SUCH PROCEDURES AND  
STANDARDS SHALL NOT LIMIT APPROVAL TO BE A HEALTH CARE ORGANIZATION IN  
THE PROGRAM FOR ECONOMIC PURPOSES AND SHALL BE CONSISTENT WITH GOOD  
PROFESSIONAL PRACTICE. IN DEVELOPING THE PROCEDURES AND STANDARDS, THE  
COMMISSIONER SHALL: (I) CONSIDER EXISTING STANDARDS DEVELOPED BY  
NATIONAL ACCREDITING AND PROFESSIONAL ORGANIZATIONS; AND (II) CONSULT  
WITH NATIONAL AND LOCAL ORGANIZATIONS WORKING IN THE FIELD OF HEALTH  
CARE ORGANIZATIONS, INCLUDING HEALTH CARE PRACTITIONERS, HOSPITALS,  
CLINICS, AND CONSUMERS AND THEIR REPRESENTATIVES. WHEN DEVELOPING AND  
IMPLEMENTING STANDARDS OF APPROVAL OF HEALTH CARE ORGANIZATIONS, THE  
COMMISSIONER SHALL CONSULT WITH THE COMMISSIONER OF MENTAL HEALTH AND  
THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES.

(B) TO MAINTAIN APPROVAL UNDER THE PROGRAM, A HEALTH CARE ORGANIZATION  
MUST: (I) RENEW ITS STATUS AT A FREQUENCY DETERMINED BY THE COMMISSION-  
ER; AND (II) PROVIDE DATA TO THE DEPARTMENT AS REQUIRED BY THE COMMIS-  
SIONER TO ENABLE THE COMMISSIONER TO EVALUATE THE HEALTH CARE ORGANIZA-

1 TION IN RELATION TO QUALITY OF HEALTH CARE SERVICES, HEALTH CARE  
2 OUTCOMES, AND COST.

3 5. THE COMMISSIONER SHALL MAKE REGULATIONS RELATING TO HEALTH CARE  
4 ORGANIZATIONS CONSISTENT WITH AND TO ENSURE COMPLIANCE WITH THIS ARTI-  
5 CLE.

6 6. THE PROVISION OF HEALTH CARE SERVICES DIRECTLY OR INDIRECTLY BY A  
7 HEALTH CARE ORGANIZATION THROUGH HEALTH CARE PROVIDERS SHALL NOT BE  
8 CONSIDERED THE PRACTICE OF A PROFESSION UNDER TITLE EIGHT OF THE EDUCA-  
9 TION LAW BY THE HEALTH CARE ORGANIZATION.

10 S 5107. PROGRAM STANDARDS. 1. THE COMMISSIONER SHALL ESTABLISH  
11 REQUIREMENTS AND STANDARDS FOR THE PROGRAM AND FOR HEALTH CARE ORGANIZA-  
12 TIONS, CARE COORDINATORS, AND HEALTH CARE PROVIDERS, INCLUDING REQUIRE-  
13 MENTS AND STANDARDS FOR, AS APPLICABLE:

14 (A) THE SCOPE, QUALITY AND ACCESSIBILITY OF HEALTH CARE SERVICES;

15 (B) RELATIONS BETWEEN HEALTH CARE ORGANIZATIONS OR HEALTH CARE PROVID-  
16 ERS AND MEMBERS, INCLUDING APPROVAL OF HEALTH CARE SERVICES; AND

17 (C) RELATIONS BETWEEN HEALTH CARE ORGANIZATIONS AND HEALTH CARE  
18 PROVIDERS, INCLUDING (I) CREDENTIALING AND PARTICIPATION IN HEALTH CARE  
19 ORGANIZATION NETWORKS; AND (II) TERMS, METHODS AND RATES OF PAYMENT.

20 2. REQUIREMENTS AND STANDARDS UNDER THE PROGRAM SHALL INCLUDE, BUT NOT  
21 BE LIMITED TO, PROVISIONS TO PROMOTE THE FOLLOWING:

22 (A) SIMPLIFICATION, TRANSPARENCY, UNIFORMITY, AND FAIRNESS IN HEALTH  
23 CARE PROVIDER CREDENTIALING AND PARTICIPATION IN HEALTH CARE ORGANIZA-  
24 TION NETWORKS, REFERRALS, PAYMENT PROCEDURES AND RATES, CLAIMS PROCESS-  
25 ING, AND APPROVAL OF HEALTH CARE SERVICES, AS APPLICABLE;

26 (B) PRIMARY AND PREVENTIVE CARE, CARE COORDINATION, EFFICIENT AND  
27 EFFECTIVE HEALTH CARE SERVICES, QUALITY ASSURANCE, AND COORDINATION AND  
28 INTEGRATION OF HEALTH CARE SERVICES, INCLUDING USE OF APPROPRIATE TECH-  
29 NOLOGY;

30 (C) ELIMINATION OF HEALTH CARE DISPARITIES;

31 (D) NON-DISCRIMINATION WITH RESPECT TO MEMBERS AND HEALTH CARE PROVID-  
32 ERS ON THE BASIS OF RACE, ETHNICITY, NATIONAL ORIGIN, RELIGION, DISABIL-  
33 ITY, AGE, SEX, SEXUAL ORIENTATION, GENDER IDENTITY OR EXPRESSION, OR  
34 ECONOMIC CIRCUMSTANCES; PROVIDED THAT HEALTH CARE SERVICES PROVIDED  
35 UNDER THE PROGRAM SHALL BE APPROPRIATE TO THE PATIENT'S CLINICALLY-RELE-  
36 VANT CIRCUMSTANCES; AND

37 (E) ACCESSIBILITY OF CARE COORDINATION, HEALTH CARE ORGANIZATION  
38 SERVICES AND HEALTH CARE SERVICES, INCLUDING ACCESSIBILITY FOR PEOPLE  
39 WITH DISABILITIES AND PEOPLE WITH LIMITED ABILITY TO SPEAK OR UNDERSTAND  
40 ENGLISH, AND THE PROVIDING OF HEALTH CARE ORGANIZATION SERVICES AND  
41 HEALTH CARE SERVICES IN A CULTURALLY COMPETENT MANNER.

42 3. ANY PARTICIPATING PROVIDER OR CARE COORDINATOR THAT IS ORGANIZED AS  
43 A FOR-PROFIT ENTITY SHALL BE REQUIRED TO MEET THE SAME REQUIREMENTS AND  
44 STANDARDS AS ENTITIES ORGANIZED AS NOT-FOR-PROFIT ENTITIES, AND PAYMENTS  
45 UNDER THE PROGRAM PAID TO SUCH ENTITIES SHALL NOT BE CALCULATED TO  
46 ACCOMMODATE THE GENERATION OF PROFIT OR REVENUE FOR DIVIDENDS OR OTHER  
47 RETURN ON INVESTMENT OR THE PAYMENT OF TAXES THAT WOULD NOT BE PAID BY A  
48 NOT-FOR-PROFIT ENTITY.

49 4. EVERY PARTICIPATING PROVIDER SHALL FURNISH TO THE PROGRAM SUCH  
50 INFORMATION TO, AND PERMIT EXAMINATION OF ITS RECORDS BY, THE PROGRAM,  
51 AS MAY BE REASONABLY REQUIRED FOR PURPOSES OF UTILIZATION REVIEW, QUALI-  
52 TY ASSURANCE, AND COST CONTAINMENT, FOR THE MAKING OF PAYMENTS, AND FOR  
53 STATISTICAL OR OTHER STUDIES OF THE OPERATION OF THE PROGRAM.

54 5. IN DEVELOPING REQUIREMENTS AND STANDARDS AND MAKING OTHER POLICY  
55 DETERMINATIONS UNDER THIS ARTICLE, THE COMMISSIONER SHALL CONSULT WITH

1 REPRESENTATIVES OF MEMBERS, HEALTH CARE PROVIDERS, HEALTH CARE ORGANIZA-  
2 TIONS AND OTHER INTERESTED PARTIES.

3 6. THE PROGRAM SHALL MAINTAIN THE CONFIDENTIALITY OF ALL DATA AND  
4 OTHER INFORMATION COLLECTED UNDER THE PROGRAM WHEN SUCH DATA WOULD BE  
5 NORMALLY CONSIDERED CONFIDENTIAL DATA BETWEEN A PATIENT AND HEALTH CARE  
6 PROVIDER. AGGREGATE DATA OF THE PROGRAM WHICH IS DERIVED FROM CONFIDEN-  
7 TIAL DATA BUT DOES NOT VIOLATE PATIENT CONFIDENTIALITY SHALL BE PUBLIC  
8 INFORMATION.

9 S 5108. REGULATIONS. THE COMMISSIONER MAY APPROVE REGULATIONS AND  
10 AMENDMENTS THERETO, UNDER SUBDIVISION ONE OF SECTION FIFTY-ONE HUNDRED  
11 TWO OF THIS ARTICLE. THE COMMISSIONER MAY MAKE REGULATIONS OR AMENDMENTS  
12 THERETO TO EFFECTUATE THE PROVISIONS AND PURPOSES OF THIS ARTICLE ON AN  
13 EMERGENCY BASIS UNDER SECTION TWO HUNDRED TWO OF THE STATE ADMINISTRA-  
14 TIVE PROCEDURE ACT, PROVIDED THAT SUCH REGULATIONS OR AMENDMENTS SHALL  
15 NOT BECOME PERMANENT UNLESS ADOPTED UNDER SUBDIVISION ONE OF SECTION  
16 FIFTY-ONE HUNDRED TWO OF THIS ARTICLE.

17 S 5109. PROVISIONS RELATING TO FEDERAL HEALTH PROGRAMS. 1. THE COMMIS-  
18 SIONER SHALL SEEK ALL FEDERAL WAIVERS AND OTHER FEDERAL APPROVALS AND  
19 ARRANGEMENTS AND SUBMIT STATE PLAN AMENDMENTS NECESSARY TO OPERATE THE  
20 PROGRAM CONSISTENT WITH THIS ARTICLE.

21 2. (A) THE COMMISSIONER SHALL APPLY TO THE SECRETARY OF HEALTH AND  
22 HUMAN SERVICES OR OTHER APPROPRIATE FEDERAL OFFICIAL FOR ALL WAIVERS OF  
23 REQUIREMENTS, AND MAKE OTHER ARRANGEMENTS, UNDER MEDICARE, ANY FEDERAL-  
24 LY-MATCHED PUBLIC HEALTH PROGRAM, THE PATIENT PROTECTION AND AFFORDABLE  
25 CARE ACT, AND ANY OTHER FEDERAL PROGRAMS THAT PROVIDE FEDERAL FUNDS FOR  
26 PAYMENT FOR HEALTH CARE SERVICES, THAT ARE NECESSARY TO ENABLE ALL NEW  
27 YORK HEALTH MEMBERS TO RECEIVE ALL BENEFITS UNDER THE PROGRAM THROUGH  
28 THE PROGRAM TO ENABLE THE STATE TO IMPLEMENT THIS ARTICLE AND TO RECEIVE  
29 AND DEPOSIT ALL FEDERAL PAYMENTS UNDER THOSE PROGRAMS (INCLUDING FUNDS  
30 THAT MAY BE PROVIDED IN LIEU OF PREMIUM TAX CREDITS, COST-SHARING SUBSI-  
31 DIES, AND SMALL BUSINESS TAX CREDITS) IN THE STATE TREASURY TO THE CRED-  
32 IT OF THE NEW YORK HEALTH TRUST FUND CREATED UNDER SECTION EIGHTY-NINE-H  
33 OF THE STATE FINANCE LAW AND TO USE THOSE FUNDS FOR THE NEW YORK HEALTH  
34 PROGRAM AND OTHER PROVISIONS UNDER THIS ARTICLE. TO THE EXTENT POSSIBLE,  
35 THE COMMISSIONER SHALL NEGOTIATE ARRANGEMENTS WITH THE FEDERAL GOVERN-  
36 MENT IN WHICH BULK OR LUMP-SUM FEDERAL PAYMENTS ARE PAID TO NEW YORK  
37 HEALTH IN PLACE OF FEDERAL SPENDING OR TAX BENEFITS FOR  
38 FEDERALLY-MATCHED HEALTH PROGRAMS OR FEDERAL HEALTH PROGRAMS.

39 (B) THE COMMISSIONER MAY REQUIRE MEMBERS OR APPLICANTS TO BE MEMBERS  
40 TO PROVIDE INFORMATION NECESSARY FOR THE PROGRAM TO COMPLY WITH ANY  
41 WAIVER OR ARRANGEMENT UNDER THIS SUBDIVISION.

42 3. (A) IF ACTIONS TAKEN UNDER SUBDIVISION TWO OF THIS SECTION DO NOT  
43 ACCOMPLISH ALL RESULTS INTENDED UNDER THAT SUBDIVISION, THEN THIS SUBDI-  
44 VISION SHALL APPLY AND SHALL AUTHORIZE ADDITIONAL ACTIONS TO EFFECTIVELY  
45 IMPLEMENT NEW YORK HEALTH TO THE MAXIMUM EXTENT POSSIBLE AS A  
46 SINGLE-PAYER PROGRAM CONSISTENT WITH THIS ARTICLE.

47 (B) THE COMMISSIONER MAY TAKE ACTIONS CONSISTENT WITH THIS ARTICLE TO  
48 ENABLE NEW YORK HEALTH TO ADMINISTER MEDICARE IN NEW YORK STATE AND TO  
49 BE A PROVIDER OF DRUG COVERAGE UNDER MEDICARE PART D FOR ELIGIBLE  
50 MEMBERS OF NEW YORK HEALTH.

51 (C) THE COMMISSIONER MAY WAIVE OR MODIFY THE APPLICABILITY OF  
52 PROVISIONS OF THIS SECTION RELATING TO ANY FEDERALLY-MATCHED PUBLIC  
53 HEALTH PROGRAM OR MEDICARE AS NECESSARY TO IMPLEMENT ANY WAIVER OR  
54 ARRANGEMENT UNDER THIS SECTION OR TO MAXIMIZE THE BENEFIT TO THE NEW  
55 YORK HEALTH PROGRAM UNDER THIS SECTION, PROVIDED THAT THE COMMISSIONER,  
56 IN CONSULTATION WITH THE DIRECTOR OF THE BUDGET, SHALL DETERMINE THAT

1 SUCH WAIVER OR MODIFICATION IS IN THE BEST INTERESTS OF THE MEMBERS  
2 AFFECTED BY THE ACTION AND THE STATE.

3 (D) THE COMMISSIONER MAY APPLY FOR COVERAGE UNDER ANY  
4 FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM ON BEHALF OF ANY MEMBER AND  
5 ENROLL THE MEMBER IN THE FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM IF THE  
6 MEMBER IS ELIGIBLE FOR IT. ENROLLMENT IN A FEDERALLY-MATCHED PUBLIC  
7 HEALTH PROGRAM SHALL NOT CAUSE ANY MEMBER TO LOSE ANY HEALTH CARE  
8 SERVICE PROVIDED BY THE PROGRAM.

9 (E) THE COMMISSIONER SHALL BY REGULATION INCREASE THE INCOME ELIGIBIL-  
10 ITY LEVEL, INCREASE OR ELIMINATE THE RESOURCE TEST FOR ELIGIBILITY,  
11 SIMPLIFY ANY PROCEDURAL OR DOCUMENTATION REQUIREMENT FOR ENROLLMENT, AND  
12 INCREASE THE BENEFITS FOR ANY FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM,  
13 NOTWITHSTANDING ANY LAW OR REGULATION TO THE CONTRARY. THE COMMISSIONER  
14 MAY ACT UNDER THIS PARAGRAPH UPON A FINDING, APPROVED BY THE DIRECTOR OF  
15 THE BUDGET, THAT THE ACTION (I) WILL HELP TO INCREASE THE NUMBER OF  
16 MEMBERS WHO ARE ELIGIBLE FOR AND ENROLLED IN FEDERALLY-MATCHED PUBLIC  
17 HEALTH PROGRAMS; (II) WILL NOT DIMINISH ANY INDIVIDUAL'S ACCESS TO ANY  
18 HEALTH CARE SERVICE; AND (III) DOES NOT REQUIRE OR HAS RECEIVED ANY  
19 NECESSARY FEDERAL WAIVERS OR APPROVALS TO ENSURE FEDERAL FINANCIAL  
20 PARTICIPATION. ACTIONS UNDER THIS PARAGRAPH SHALL NOT APPLY TO ELIGIBIL-  
21 ITY FOR PAYMENT FOR LONG TERM CARE.

22 (F) TO ENABLE THE COMMISSIONER TO APPLY FOR COVERAGE UNDER ANY FEDER-  
23 ALLY-MATCHED PUBLIC HEALTH PROGRAM ON BEHALF OF ANY MEMBER AND ENROLL  
24 THE MEMBER IN THE FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM IF THE MEMBER  
25 IS ELIGIBLE FOR IT, THE COMMISSIONER MAY REQUIRE THAT EVERY MEMBER OR  
26 APPLICANT TO BE A MEMBER SHALL PROVIDE INFORMATION TO ENABLE THE COMMIS-  
27 SIONER TO DETERMINE WHETHER THE APPLICANT IS ELIGIBLE FOR A  
28 FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM AND FOR MEDICARE (AND ANY  
29 PROGRAM OR BENEFIT UNDER MEDICARE). THE PROGRAM SHALL MAKE A REASONABLE  
30 EFFORT TO NOTIFY MEMBERS OF THEIR OBLIGATIONS UNDER THIS PARAGRAPH.  
31 AFTER A REASONABLE EFFORT HAS BEEN MADE TO CONTACT THE MEMBER, THE  
32 MEMBER SHALL BE NOTIFIED IN WRITING THAT HE OR SHE HAS SIXTY DAYS TO  
33 PROVIDE SUCH REQUIRED INFORMATION. IF SUCH INFORMATION IS NOT PROVIDED  
34 WITHIN THE SIXTY DAY PERIOD, THE MEMBER'S COVERAGE UNDER THE PROGRAM MAY  
35 BE TERMINATED.

36 (G) AS A CONDITION OF CONTINUED ELIGIBILITY FOR HEALTH CARE SERVICES  
37 UNDER THE PROGRAM, A MEMBER WHO IS ELIGIBLE FOR BENEFITS UNDER MEDICARE  
38 SHALL ENROLL IN MEDICARE, INCLUDING PARTS A, B AND D.

39 (H) THE PROGRAM SHALL PROVIDE PREMIUM ASSISTANCE FOR ALL MEMBERS  
40 ENROLLING IN A MEDICARE PART D DRUG COVERAGE UNDER SECTION 1860D OF  
41 TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT LIMITED TO THE LOW-INCOME  
42 BENCHMARK PREMIUM AMOUNT ESTABLISHED BY THE FEDERAL CENTERS FOR MEDICARE  
43 AND MEDICAID SERVICES AND ANY OTHER AMOUNT WHICH SUCH AGENCY ESTABLISHES  
44 UNDER ITS DE MINIMIS PREMIUM POLICY, EXCEPT THAT SUCH PAYMENTS MADE ON  
45 BEHALF OF MEMBERS ENROLLED IN A MEDICARE ADVANTAGE PLAN MAY EXCEED THE  
46 LOW-INCOME BENCHMARK PREMIUM AMOUNT IF DETERMINED TO BE COST EFFECTIVE  
47 TO THE PROGRAM.

48 (I) IF THE COMMISSIONER HAS REASONABLE GROUNDS TO BELIEVE THAT A  
49 MEMBER COULD BE ELIGIBLE FOR AN INCOME-RELATED SUBSIDY UNDER SECTION  
50 1860D-14 OF TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT, THE MEMBER  
51 SHALL PROVIDE, AND AUTHORIZE THE PROGRAM TO OBTAIN, ANY INFORMATION OR  
52 DOCUMENTATION REQUIRED TO ESTABLISH THE MEMBER'S ELIGIBILITY FOR SUCH  
53 SUBSIDY, PROVIDED THAT THE COMMISSIONER SHALL ATTEMPT TO OBTAIN AS MUCH  
54 OF THE INFORMATION AND DOCUMENTATION AS POSSIBLE FROM RECORDS THAT ARE  
55 AVAILABLE TO HIM OR HER.

(J) THE PROGRAM SHALL MAKE A REASONABLE EFFORT TO NOTIFY MEMBERS OF THEIR OBLIGATIONS UNDER THIS SUBDIVISION. AFTER A REASONABLE EFFORT HAS BEEN MADE TO CONTACT THE MEMBER, THE MEMBER SHALL BE NOTIFIED IN WRITING THAT HE OR SHE HAS SIXTY DAYS TO PROVIDE SUCH REQUIRED INFORMATION. IF SUCH INFORMATION IS NOT PROVIDED WITHIN THE SIXTY DAY PERIOD, THE MEMBER'S COVERAGE UNDER THE PROGRAM MAY BE TERMINATED.

S 5110. ADDITIONAL PROVISIONS. 1. THE COMMISSIONER SHALL CONTRACT WITH NOT-FOR-PROFIT ORGANIZATIONS TO PROVIDE:

(A) CONSUMER ASSISTANCE TO INDIVIDUALS WITH RESPECT TO SELECTION OF A CARE COORDINATOR OR HEALTH CARE ORGANIZATION, ENROLLING, OBTAINING HEALTH CARE SERVICES, DISENROLLING, AND OTHER MATTERS RELATING TO THE PROGRAM;

(B) HEALTH CARE PROVIDER ASSISTANCE TO HEALTH CARE PROVIDERS PROVIDING AND SEEKING OR CONSIDERING WHETHER TO PROVIDE, HEALTH CARE SERVICES UNDER THE PROGRAM, WITH RESPECT TO PARTICIPATING IN A HEALTH CARE ORGANIZATION AND DEALING WITH A HEALTH CARE ORGANIZATION; AND

(C) CARE COORDINATOR ASSISTANCE TO INDIVIDUALS AND ENTITIES PROVIDING AND SEEKING OR CONSIDERING WHETHER TO PROVIDE, CARE COORDINATION TO MEMBERS.

2. THE COMMISSIONER SHALL PROVIDE GRANTS FROM FUNDS IN THE NEW YORK HEALTH TRUST FUND OR OTHERWISE APPROPRIATED FOR THIS PURPOSE, TO HEALTH SYSTEMS AGENCIES UNDER SECTION TWENTY-NINE HUNDRED FOUR-B OF THIS CHAPTER TO SUPPORT THE OPERATION OF SUCH HEALTH SYSTEMS AGENCIES.

S 3. Financing of New York Health. 1. The governor shall submit to the legislature a plan and legislative bills to implement the plan (referred to collectively in this section as the "revenue proposal") to provide the revenue necessary to finance the New York Health program, as created by article 51 of the public health law (referred to in this section as the "program"), taking into consideration anticipated federal revenue available for the program. The revenue proposal shall be submitted to the legislature as part of the executive budget under article VII of the state constitution, for the fiscal year commencing on the first day of April in the calendar year after this act shall become a law. In developing the revenue proposal, the governor shall consult with appropriate officials of the executive branch; the temporary president of the senate; the speaker of the assembly; the chairs of the fiscal and health committees of the senate and assembly; and representatives of business, labor, consumers and local government.

2. (a) Basic structure. The basic structure of the revenue proposal shall be as follows: Revenue for the program shall come from two assessments (referred to collectively in this section as the "assessments"). First, there shall be an assessment on all payroll and self-employed income (referred to in this section as the "payroll assessment"), paid by employers, employees and self-employed, similar to the Medicare tax. Higher brackets of income subject to this assessment shall be assessed at a higher marginal rate than lower brackets. Second, there shall be a progressively-graduated assessment on taxable income (such as interest, dividends, and capital gains) not subject to the payroll assessment (referred to in this section as the "non-payroll assessment"). The assessments will be set at levels anticipated to produce sufficient revenue to finance the program and other provisions of article 51 of the public health law, to be scaled up as enrollment grows, taking into consideration anticipated federal revenue available for the program. Provision shall be made for state residents (who are eligible for the program) who are employed out-of-state, and non-residents (who are not eligible for the program) who are employed in the state.

(b) Payroll assessment. The income to be subject to the payroll assessment shall be all income subject to the Medicare tax. The assessment shall be set at a particular percentage of that income, which shall be progressively graduated, so the percentage is higher on higher brackets of income. For employed individuals, the employer shall pay eighty percent of the assessment and the employee shall pay twenty percent (unless the employer agrees to pay a higher percentage). A self-employed individual shall pay the full assessment.

(c) Non-payroll income assessment. There shall be a second assessment, on upper-bracket taxable income that is not subject to the payroll assessment. It shall be progressively graduated and structured as a percentage of the personal income tax on that income.

(d) Phased-in rates. Early in the program, when enrollment is growing, the amount of the assessments shall be at an appropriate level, and shall be raised as anticipated enrollment grows, to cover the actual cost of the program and other provisions of article 51 of the public health law. The revenue proposal shall include a mechanism for determining the rates of the assessments.

(e) Cross-border employees. (i) State residents employed out-of-state. If an individual is employed out-of-state by an employer that is subject to New York state law, the employer and employee shall be required to pay the payroll assessment as if the employment were in the state. If an individual is employed out-of-state by an employer that is not subject to New York state law, either (A) the employer and employee shall voluntarily comply with the assessment or (B) the employee shall pay the assessment as if he or she were self-employed.

(ii) Out-of-state residents employed in the state. (A) The payroll assessment shall apply to any out-of-state resident who is employed or self-employed in the state. (B) In the case of an out-of-state resident who is employed or self-employed in the state, such individual's employer (which term shall include a Taft-Hartley fund) shall be able to take a credit against the payroll assessments they would otherwise pay, for amounts they spend on health benefits that would otherwise be covered by the program. For employers, the credit shall be available regardless of the form of the health benefit (e.g., health insurance, a self-insured plan, direct services, or reimbursement for services), to make sure that the revenue proposal does not relate to employment benefits in violation of the federal ERISA. An employee may take the credit for his or her contribution to an employment-based health benefit. For non-employment-based spending by individuals, the credit shall be available for and limited to spending for health coverage (not out-of-pocket health spending). The credit shall be available without regard to how little is spent or how sparse the benefit. The credit may only be taken against the payroll assessments. Any excess amount may not be applied to other tax liability. For employment-based health benefits, the credit shall be distributed between the employer and employee in the same proportion as the spending by each for the benefit. The employer and employee may each apply their respective portion of the credit to their respective portion of the assessment. If any provision of this clause (B) or any application of it shall be ruled to violate federal ERISA, the provision or the application of it shall be null and void and the ruling shall not affect any other provision or application of this section or the act that enacted it.

3. The revenue proposal shall include a plan and legislative provisions for ending the requirement for local social services

districts to pay part of the cost of Medicaid and replacing those payments with revenue from the assessments under the revenue proposal.

4. To the extent that the revenue proposal differs from the terms of subdivision 2 of this section, the revenue proposal shall state how it differs from those terms and reasons for and the effects of the differences.

5. All revenue from the assessments shall be deposited in the New York Health trust fund account under section 89-h of the state finance law.

S 4. Article 49 of the public health law is amended by adding a new title 3 to read as follows:

### TITLE III

#### COLLECTIVE NEGOTIATIONS BY HEALTH CARE PROVIDERS WITH NEW YORK HEALTH

##### SECTION 4920. DEFINITIONS.

4921. COLLECTIVE NEGOTIATION AUTHORIZED.

4922. COLLECTIVE NEGOTIATION REQUIREMENTS.

4923. REQUIREMENTS FOR HEALTH CARE PROVIDERS' REPRESENTATIVE.

4924. CERTAIN COLLECTIVE ACTION PROHIBITED.

4925. FEES.

4926. CONFIDENTIALITY.

4927. SEVERABILITY AND CONSTRUCTION.

S 4920. DEFINITIONS. FOR PURPOSES OF THIS TITLE:

1. "NEW YORK HEALTH" MEANS THE PROGRAM UNDER ARTICLE FIFTY-ONE OF THIS CHAPTER.

2. "PERSON" MEANS AN INDIVIDUAL, ASSOCIATION, CORPORATION, OR ANY OTHER LEGAL ENTITY.

3. "HEALTH CARE PROVIDERS' REPRESENTATIVE" MEANS A THIRD PARTY WHO IS AUTHORIZED BY HEALTH CARE PROVIDERS TO NEGOTIATE ON THEIR BEHALF WITH NEW YORK HEALTH OVER TERMS AND CONDITIONS AFFECTING THOSE HEALTH CARE PROVIDERS.

4. "STRIKE" MEANS A WORK STOPPAGE IN PART OR IN WHOLE, DIRECT OR INDIRECT, BY A BODY OF WORKERS TO GAIN COMPLIANCE WITH DEMANDS MADE ON AN EMPLOYER.

5. "HEALTH CARE PROVIDER" MEANS A PERSON WHO IS LICENSED, CERTIFIED, OR REGISTERED PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW AND WHO PRACTICES AS A HEALTH CARE PROVIDER AS AN INDEPENDENT CONTRACTOR OR WHO IS AN OWNER, OFFICER, SHAREHOLDER, OR PROPRIETOR OF A HEALTH CARE PROVIDER; OR AN ENTITY THAT EMPLOYS OR UTILIZES HEALTH CARE PROVIDERS TO PROVIDE HEALTH CARE SERVICES, INCLUDING BUT NOT LIMITED TO A HOSPITAL LICENSED UNDER ARTICLE TWENTY-EIGHT OF THIS CHAPTER OR AN ACCOUNTABLE CARE ORGANIZATION UNDER ARTICLE TWENTY-NINE-E OF THIS CHAPTER. A HEALTH CARE PROVIDER UNDER TITLE EIGHT OF THE EDUCATION LAW WHO PRACTICES AS AN EMPLOYEE OF A HEALTH CARE PROVIDER SHALL NOT BE DEEMED A HEALTH CARE PROVIDER FOR PURPOSES OF THIS TITLE.

S 4921. COLLECTIVE NEGOTIATION AUTHORIZED. 1. HEALTH CARE PROVIDERS MAY MEET AND COMMUNICATE FOR THE PURPOSE OF COLLECTIVELY NEGOTIATING THE FOLLOWING TERMS AND CONDITIONS OF PROVIDER CONTRACTS WITH NEW YORK HEALTH:

(A) THE DETAILS OF THE UTILIZATION REVIEW PLAN AS DEFINED PURSUANT TO SUBDIVISION TEN OF SECTION FORTY-NINE HUNDRED OF THIS ARTICLE;

(B) THE DEFINITION OF MEDICAL NECESSITY;

(C) THE CLINICAL PRACTICE GUIDELINES USED TO MAKE MEDICAL NECESSITY AND UTILIZATION REVIEW DETERMINATIONS;

(D) PREVENTIVE CARE AND OTHER MEDICAL COORDINATION PRACTICES;

(E) DRUG FORMULARIES AND STANDARDS AND PROCEDURES FOR PRESCRIBING OFF-FORMULARY DRUGS;



(F) THE DETAILS OF RISK TRANSFER ARRANGEMENTS WITH PROVIDERS;  
(G) ADMINISTRATIVE PROCEDURES;  
(H) PROCEDURES TO BE UTILIZED TO RESOLVE DISPUTES BETWEEN NEW YORK HEALTH AND HEALTH CARE PROVIDERS;  
(I) PATIENT REFERRAL PROCEDURES;  
(J) THE FORMULATION AND APPLICATION OF HEALTH CARE PROVIDER REIMBURSEMENT PROCEDURES;  
(K) QUALITY ASSURANCE PROGRAMS;  
(L) THE PROCESS FOR RENDERING UTILIZATION REVIEW DETERMINATIONS INCLUDING: ESTABLISHMENT OF A PROCESS FOR RENDERING UTILIZATION REVIEW DETERMINATIONS WHICH SHALL, AT A MINIMUM, INCLUDE: WRITTEN PROCEDURES TO ASSURE THAT UTILIZATION REVIEWS AND DETERMINATIONS ARE CONDUCTED WITHIN THE TIMEFRAMES ESTABLISHED IN THIS ARTICLE; PROCEDURES TO NOTIFY AN ENROLLEE, AN ENROLLEE'S DESIGNEE AND/OR AN ENROLLEE'S HEALTH CARE PROVIDER OF ADVERSE DETERMINATIONS; AND PROCEDURES FOR APPEAL OF ADVERSE DETERMINATIONS, INCLUDING THE ESTABLISHMENT OF AN EXPEDITED APPEALS PROCESS FOR DENIALS OF CONTINUED INPATIENT CARE OR WHERE THERE IS IMMINENT OR SERIOUS THREAT TO THE HEALTH OF THE ENROLLEE;  
(M) HEALTH CARE PROVIDER SELECTION AND TERMINATION CRITERIA USED BY NEW YORK HEALTH;  
(N) THE FEES ASSESSED BY NEW YORK HEALTH FOR SERVICES, INCLUDING FEES ESTABLISHED THROUGH THE APPLICATION OF REIMBURSEMENT PROCEDURES;  
(O) THE CONVERSION FACTORS USED BY NEW YORK HEALTH IN A RESOURCE-BASED RELATIVE VALUE SCALE REIMBURSEMENT METHODOLOGY OR OTHER SIMILAR METHODOLOGY; PROVIDED THE SAME ARE NOT OTHERWISE ESTABLISHED BY STATE OR FEDERAL LAW OR REGULATION;  
(P) THE AMOUNT OF ANY DISCOUNT GRANTED BY NEW YORK HEALTH ON THE FEE OF HEALTH CARE SERVICES TO BE RENDERED BY HEALTH CARE PROVIDERS;  
(Q) THE DOLLAR AMOUNT OF CAPITATION OR FIXED PAYMENT FOR HEALTH CARE SERVICES RENDERED BY HEALTH CARE PROVIDERS TO NEW YORK HEALTH MEMBERS;  
(R) THE PROCEDURE CODE OR OTHER DESCRIPTION OF A HEALTH CARE SERVICE COVERED BY A PAYMENT AND THE APPROPRIATE GROUPING OF THE PROCEDURE CODES; AND  
(S) THE AMOUNT OF ANY OTHER COMPONENT OF THE REIMBURSEMENT METHODOLOGY FOR A HEALTH CARE SERVICE.

2. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO ALLOW OR AUTHORIZE AN ALTERATION OF THE TERMS OF THE INTERNAL AND EXTERNAL REVIEW PROCEDURES SET FORTH IN LAW.

3. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO ALLOW A STRIKE OF NEW YORK HEALTH BY HEALTH CARE PROVIDERS.

4. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO ALLOW OR AUTHORIZE TERMS OR CONDITIONS WHICH WOULD IMPEDE THE ABILITY OF NEW YORK HEALTH TO OBTAIN OR RETAIN ACCREDITATION BY THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE OR A SIMILAR BODY OR TO COMPLY WITH APPLICABLE STATE OR FEDERAL LAW.

5. NOTHING IN THIS SECTION SHALL BE DEEMED TO AFFECT OR LIMIT THE RIGHT OF A HEALTH CARE PROVIDER OR GROUP OF HEALTH CARE PROVIDERS TO COLLECTIVELY PETITION A GOVERNMENT ENTITY FOR A CHANGE IN A LAW, RULE, OR REGULATION.

S 4922. COLLECTIVE NEGOTIATION REQUIREMENTS. 1. COLLECTIVE NEGOTIATION RIGHTS GRANTED BY THIS TITLE MUST CONFORM TO THE FOLLOWING REQUIREMENTS:

(A) HEALTH CARE PROVIDERS MAY COMMUNICATE WITH OTHER HEALTH CARE PROVIDERS REGARDING THE TERMS AND CONDITIONS TO BE NEGOTIATED WITH NEW YORK HEALTH;

(B) HEALTH CARE PROVIDERS MAY COMMUNICATE WITH HEALTH CARE PROVIDERS' REPRESENTATIVES;

1 (C) A HEALTH CARE PROVIDERS' REPRESENTATIVE IS THE ONLY PARTY AUTHOR-  
2 IZED TO NEGOTIATE WITH NEW YORK HEALTH ON BEHALF OF THE HEALTH CARE  
3 PROVIDERS AS A GROUP;

4 (D) A HEALTH CARE PROVIDER CAN BE BOUND BY THE TERMS AND CONDITIONS  
5 NEGOTIATED BY THE HEALTH CARE PROVIDERS' REPRESENTATIVES; AND

6 (E) IN COMMUNICATING OR NEGOTIATING WITH THE HEALTH CARE PROVIDERS'  
7 REPRESENTATIVE, NEW YORK HEALTH IS ENTITLED TO OFFER AND PROVIDE DIFFER-  
8 ENT TERMS AND CONDITIONS TO INDIVIDUAL COMPETING HEALTH CARE PROVIDERS.

9 2. NOTHING IN THIS TITLE SHALL BE CONSTRUED TO PROHIBIT OR LIMIT  
10 COLLECTIVE ACTION OR COLLECTIVE BARGAINING ON THE PART OF ANY HEALTH  
11 CARE PROVIDER WITH HIS OR HER EMPLOYER OR ANY OTHER LAWFUL COLLECTIVE  
12 ACTION OR COLLECTIVE BARGAINING.

13 S 4923. REQUIREMENTS FOR HEALTH CARE PROVIDERS' REPRESENTATIVE. BEFORE  
14 ENGAGING IN COLLECTIVE NEGOTIATIONS WITH NEW YORK HEALTH ON BEHALF OF  
15 HEALTH CARE PROVIDERS, A HEALTH CARE PROVIDERS' REPRESENTATIVE SHALL  
16 FILE WITH THE COMMISSIONER, IN THE MANNER PRESCRIBED BY THE COMMISSION-  
17 ER, INFORMATION IDENTIFYING THE REPRESENTATIVE, THE REPRESENTATIVE'S  
18 PLAN OF OPERATION, AND THE REPRESENTATIVE'S PROCEDURES TO ENSURE COMPLI-  
19 ANCE WITH THIS TITLE.

20 S 4924. CERTAIN COLLECTIVE ACTION PROHIBITED. 1. THIS TITLE IS NOT  
21 INTENDED TO AUTHORIZE COMPETING HEALTH CARE PROVIDERS TO ACT IN CONCERT  
22 IN RESPONSE TO A HEALTH CARE PROVIDERS' REPRESENTATIVE'S DISCUSSIONS OR  
23 NEGOTIATIONS WITH NEW YORK HEALTH.

24 2. NO HEALTH CARE PROVIDERS' REPRESENTATIVE SHALL NEGOTIATE ANY AGREE-  
25 MENT THAT EXCLUDES, LIMITS THE PARTICIPATION OR REIMBURSEMENT OF, OR  
26 OTHERWISE LIMITS THE SCOPE OF SERVICES TO BE PROVIDED BY ANY HEALTH CARE  
27 PROVIDER OR GROUP OF HEALTH CARE PROVIDERS WITH RESPECT TO THE PERFORM-  
28 ANCE OF SERVICES THAT ARE WITHIN THE HEALTH CARE PROVIDER'S SCOPE OF  
29 PRACTICE, LICENSE, REGISTRATION, OR CERTIFICATE.

30 S 4925. FEES. EACH PERSON WHO ACTS AS THE REPRESENTATIVE OR NEGOTIAT-  
31 ING PARTIES UNDER THIS TITLE SHALL PAY TO THE DEPARTMENT A FEE TO ACT AS  
32 A REPRESENTATIVE. THE COMMISSIONER, BY RULE, SHALL SET FEES IN AMOUNTS  
33 DEEMED REASONABLE AND NECESSARY TO COVER THE COSTS INCURRED BY THE  
34 DEPARTMENT IN ADMINISTERING THIS TITLE.

35 S 4926. CONFIDENTIALITY. ALL REPORTS AND OTHER INFORMATION REQUIRED TO  
36 BE REPORTED TO THE DEPARTMENT UNDER THIS TITLE SHALL NOT BE SUBJECT TO  
37 DISCLOSURE UNDER ARTICLE SIX OF THE PUBLIC OFFICERS LAW OR ARTICLE THIR-  
38 TY-ONE OF THE CIVIL PRACTICE LAW AND RULES.

39 S 4927. SEVERABILITY AND CONSTRUCTION. IF ANY PROVISION OR APPLICATION  
40 OF THIS TITLE SHALL BE HELD TO BE INVALID, OR TO VIOLATE OR BE INCON-  
41 SISTENT WITH ANY APPLICABLE FEDERAL LAW OR REGULATION, THAT SHALL NOT  
42 AFFECT OTHER PROVISIONS OR APPLICATIONS OF THIS TITLE WHICH CAN BE GIVEN  
43 EFFECT WITHOUT THAT PROVISION OR APPLICATION; AND TO THAT END, THE  
44 PROVISIONS AND APPLICATIONS OF THIS TITLE ARE SEVERABLE. THE PROVISIONS  
45 OF THIS TITLE SHALL BE LIBERALLY CONSTRUED TO GIVE EFFECT TO THE  
46 PURPOSES THEREOF.

47 S 5. Subdivision 11 of section 270 of the public health law, as  
48 amended by section 2-a of part C of chapter 58 of the laws of 2008, is  
49 amended to read as follows:

50 11. "State public health plan" means the medical assistance program  
51 established by title eleven of article five of the social services law  
52 (referred to in this article as "Medicaid"), the elderly pharmaceutical  
53 insurance coverage program established by title three of article two of  
54 the elder law (referred to in this article as "EPIC"), [and] the family  
55 health plus program established by section three hundred sixty-nine-ee  
56 of the social services law to the extent that section provides that the

1 program shall be subject to this article, AND THE NEW YORK HEALTH  
2 PROGRAM ESTABLISHED BY ARTICLE FIFTY-ONE OF THIS CHAPTER.

3 S 6. The state finance law is amended by adding a new section 89-h to  
4 read as follows:

5 S 89-H. NEW YORK HEALTH TRUST FUND. 1. THERE IS HEREBY ESTABLISHED IN  
6 THE JOINT CUSTODY OF THE STATE COMPTROLLER AND THE COMMISSIONER OF TAXA-  
7 TION AND FINANCE A SPECIAL REVENUE FUND TO BE KNOWN AS THE "NEW YORK  
8 HEALTH TRUST FUND", HEREINAFTER KNOWN AS "THE FUND". THE DEFINITIONS IN  
9 SECTION FIFTY-ONE HUNDRED OF THE PUBLIC HEALTH LAW SHALL APPLY TO THIS  
10 SECTION.

11 2. THE FUND SHALL CONSIST OF:

12 (A) ALL MONIES OBTAINED FROM ASSESSMENTS PURSUANT TO LEGISLATION  
13 ENACTED AS PROPOSED UNDER SECTION THREE OF THE CHAPTER OF THE LAWS OF  
14 NEW YORK THAT ADDED THIS SECTION;

15 (B) FEDERAL PAYMENTS RECEIVED AS A RESULT OF ANY WAIVER OF REQUIRE-  
16 MENTS GRANTED OR OTHER ARRANGEMENTS AGREED TO BY THE UNITED STATES  
17 SECRETARY OF HEALTH AND HUMAN SERVICES OR OTHER APPROPRIATE FEDERAL  
18 OFFICIALS FOR HEALTH CARE PROGRAMS ESTABLISHED UNDER MEDICARE, ANY  
19 FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM, OR THE PATIENT PROTECTION AND  
20 AFFORDABLE CARE ACT;

21 (C) THE AMOUNTS PAID BY THE DEPARTMENT OF HEALTH AND BY LOCAL SOCIAL  
22 SERVICES DISTRICTS THAT ARE EQUIVALENT TO THOSE AMOUNTS THAT ARE PAID ON  
23 BEHALF OF RESIDENTS OF THIS STATE UNDER MEDICARE, ANY FEDERALLY-MATCHED  
24 PUBLIC HEALTH PROGRAM, OR THE PATIENT PROTECTION AND AFFORDABLE CARE ACT  
25 FOR HEALTH BENEFITS WHICH ARE EQUIVALENT TO HEALTH BENEFITS COVERED  
26 UNDER NEW YORK HEALTH;

27 (D) ALL SURCHARGES THAT ARE IMPOSED ON RESIDENTS OF THIS STATE TO  
28 REPLACE PAYMENTS MADE BY THE RESIDENTS UNDER THE COST-SHARING PROVISIONS  
29 OF MEDICARE;

30 (E) FEDERAL, STATE AND LOCAL FUNDS FOR PURPOSES OF THE PROVISION OF  
31 SERVICES AUTHORIZED UNDER TITLE XX OF THE FEDERAL SOCIAL SECURITY ACT  
32 THAT WOULD OTHERWISE BE COVERED UNDER ARTICLE FIFTY-ONE OF THE PUBLIC  
33 HEALTH LAW; AND

34 (F) STATE AND LOCAL GOVERNMENT MONIES THAT WOULD OTHERWISE BE APPRO-  
35 PRIATED TO ANY GOVERNMENTAL AGENCY, OFFICE, PROGRAM, INSTRUMENTALITY OR  
36 INSTITUTION WHICH PROVIDES HEALTH SERVICES, FOR SERVICES AND BENEFITS  
37 COVERED UNDER NEW YORK HEALTH. PAYMENTS TO THE FUND PURSUANT TO THIS  
38 PARAGRAPH SHALL BE IN AN AMOUNT EQUAL TO THE MONEY APPROPRIATED FOR SUCH  
39 PURPOSES IN THE FISCAL YEAR IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF  
40 ARTICLE FIFTY-ONE OF THE PUBLIC HEALTH LAW.

41 3. MONIES IN THE FUND SHALL ONLY BE USED FOR PURPOSES ESTABLISHED  
42 UNDER ARTICLE FIFTY-ONE OF THE PUBLIC HEALTH LAW.

43 S 7. Temporary commission on implementation. 1. There is hereby estab-  
44 lished a temporary commission on implementation of the New York Health  
45 program, hereinafter to be known as the commission, consisting of  
46 fifteen members: five members, including the chair, shall be appointed  
47 by the governor; four members shall be appointed by the temporary presi-  
48 dent of the senate, one member shall be appointed by the senate minority  
49 leader; four members shall be appointed by the speaker of the assembly,  
50 and one member shall be appointed by the assembly minority leader. The  
51 commissioner of health, the superintendent of financial services, and  
52 the commissioner of taxation and finance, or their designees shall serve  
53 as non-voting ex-officio members of the commission.

54 2. Members of the commission shall receive such assistance as may be  
55 necessary from other state agencies and entities, and shall receive  
56 necessary expenses incurred in the performance of their duties. The

1 commission may employ staff as needed, prescribe their duties, and fix  
2 their compensation within amounts appropriate for the commission.

3 3. The commission shall examine the laws and regulations of the state  
4 and make such recommendations as are necessary to conform the laws and  
5 regulations of the state and article 51 of the public health law estab-  
6 lishing the New York Health program and other provisions of law relating  
7 to the New York Health program, and to improve and implement the  
8 program. The commission shall report its recommendations to the governor  
9 and the legislature.

10 S 8. Severability. If any provision or application of this act shall  
11 be held to be invalid, or to violate or be inconsistent with any appli-  
12 cable federal law or regulation, that shall not affect other provisions  
13 or applications of this act which can be given effect without that  
14 provision or application; and to that end, the provisions and applica-  
15 tions of this act are severable.

16 S 9. This act shall take effect immediately.