S T A T E O F N E W Y O R K

3690

2013-2014 Regular Sessions

I N S E N A T E

February 11, 2013

Introduced by Sen. HANNON -- read twice and ordered printed, and when printed to be committed to the Committee on Health

AN ACT to amend the public health law, in relation to requirements for collective negotiations by health care providers with certain health benefit plans

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

Section 1. Statement of legislative intent. The legislature finds that collective negotiation by competing health care providers for the terms and conditions of contracts with health plans can result in beneficial results for health care consumers. The legislature further finds instances where health plans dominate the market to such a degree that fair and adequate negotiations between health care providers and the plans are adversely affected, so that it is necessary and appropriate to provide for a system of collective action on behalf of health care providers. Consequently, the legislature finds it appropriate and necessary to displace competition with regulation of health plan-provider agreements and authorize collective negotiations on the terms and conditions of the relationship between health care plans and health care providers so the imbalances between the two will not result in adverse conditions of health care. This act is not intended to apply to or affect in any respect collective bargaining relationships which arise under applicable federal or state collective bargaining statutes.

S 2. This act shall be known and may be cited as the "health care consumer and provider protection act".

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

TITLE III

COLLECTIVE NEGOTIATIONS BY HEALTH CARE PROVIDERS WITH HEALTH CARE PLANS

SECTION 4920. DEFINITIONS.

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

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S 4920. DEFINITIONS. FOR PURPOSES OF THIS TITLE:

1. "HEALTH CARE PLAN" MEANS AN ENTITY (OTHER THAN A HEALTH CARE PROVIDER) THAT APPROVES, PROVIDES, ARRANGES FOR, OR PAYS FOR HEALTH CARE SERVICES, INCLUDING BUT NOT LIMITED TO:

(A) A HEALTH MAINTENANCE ORGANIZATION LICENSED PURSUANT TO ARTICLE FORTY-THREE OF THE INSURANCE LAW OR CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THIS CHAPTER;

(B) ANY OTHER ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THIS CHAPTER; OR

(C) AN INSURER OR CORPORATION SUBJECT TO THE INSURANCE LAW.

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 HEALTH CARE PLANS OVER CONTRACTUAL TERMS AND CONDITIONS AFFECTING THOSE HEALTH CARE PROVIDERS.

4. "STRIKE" MEANS A WORK STOPPAGE IN PART OR IN WHOLE, DIRECT OR INDIRECT, BY A HEALTH CARE PROVIDER OR HEALTH CARE PROVIDERS TO GAIN COMPLIANCE WITH DEMANDS MADE ON A HEALTH CARE PLAN.

5. "SUBSTANTIAL MARKET SHARE IN A BUSINESS LINE" EXISTS IF A HEALTH CARE PLAN'S MARKET SHARE OF A BUSINESS LINE WITHIN THE GEOGRAPHIC AREA FOR WHICH A NEGOTIATION HAS BEEN APPROVED BY THE COMMISSIONER, ALONE OR IN COMBINATION WITH THE MARKET SHARES OF AFFILIATES, EXCEEDS EITHER TEN PERCENT OF THE TOTAL NUMBER OF COVERED LIVES IN THAT SERVICE AREA FOR SUCH BUSINESS LINE OR TWENTY-FIVE THOUSAND LIVES, OR IF THE COMMISSIONER DETERMINES THE MARKET SHARE OF THE INSURER IN THE RELEVANT INSURANCE PRODUCT AND GEOGRAPHIC MARKETS FOR THE SERVICES OF THE PROVIDERS SEEKING TO COLLECTIVELY NEGOTIATE SIGNIFICANTLY EXCEEDS THE COUNTERVAILING MARKET SHARE OF THE PROVIDERS ACTING INDIVIDUALLY.

6. "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 AND/OR WHO IS AN OWNER, OFFICER, SHAREHOLDER, OR PROPRIETOR OF A HEALTH CARE PROVIDER. 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. NON-FEE RELATED COLLECTIVE NEGOTIATION AUTHORIZED. 1. HEALTH CARE PROVIDERS PRACTICING WITHIN THE GEOGRAPHIC AREA FOR WHICH A NEGOTIATION HAS BEEN APPROVED BY THE COMMISSIONER MAY MEET AND COMMUNICATE FOR THE PURPOSE OF COLLECTIVELY NEGOTIATING THE FOLLOWING TERMS AND CONDITIONS OF PROVIDER CONTRACTS WITH THE HEALTH CARE PLAN:

(A) THE DETAILS OF THE UTILIZATION REVIEW PLAN AS DEFINED PURSUANT TO SUBDIVISION TEN OF SECTION FORTY-NINE HUNDRED OF THIS ARTICLE AND SUBSECTION (J) OF SECTION FOUR THOUSAND NINE HUNDRED OF THE INSURANCE LAW;

(B) COVERAGE PROVISIONS; HEALTH CARE BENEFITS; BENEFIT MAXIMUMS, INCLUDING BENEFIT LIMITATIONS; AND EXCLUSIONS OF COVERAGE;

(C) THE DEFINITION OF MEDICAL NECESSITY;
(D) THE CLINICAL PRACTICE GUIDELINES USED TO MAKE MEDICAL NECESSITY AND UTILIZATION REVIEW DETERMINATIONS;
(E) PREVENTIVE CARE AND OTHER MEDICAL MANAGEMENT PRACTICES;
(F) DRUG FORMULARIES AND STANDARDS AND PROCEDURES FOR PRESCRIBING OFF-FORMULARY DRUGS;
(G) RESPECTIVE PHYSICIAN LIABILITY FOR THE TREATMENT OR LACK OF TREATMENT OF COVERED PERSONS;
(H) THE DETAILS OF HEALTH CARE PLAN RISK TRANSFER ARRANGEMENTS WITH PROVIDERS;
(I) PLAN ADMINISTRATIVE PROCEDURES, INCLUDING METHODS AND TIMING OF HEALTH CARE PROVIDER PAYMENT FOR SERVICES;
(J) PROCEDURES TO BE UTILIZED TO RESOLVE DISPUTES BETWEEN THE HEALTH CARE PLAN AND HEALTH CARE PROVIDERS;
(K) PATIENT REFERRAL PROCEDURES INCLUDING, BUT NOT LIMITED TO, THOSE APPLICABLE TO OUT-OF-NETWORK REFERRALS;
(L) THE FORMULATION AND APPLICATION OF HEALTH CARE PROVIDER REIMBURSEMENT PROCEDURES;
(M) QUALITY ASSURANCE PROGRAMS;
(N) 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; AND
(O) HEALTH CARE PROVIDER SELECTION AND TERMINATION CRITERIA USED BY THE HEALTH CARE PLAN.
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 A HEALTH CARE PLAN BY HEALTH CARE PROVIDERS OR PLANS AS OTHERWISE SET FORTH IN THE LAWS OF THIS STATE.
4. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO ALLOW OR AUTHORIZE TERMS OR CONDITIONS WHICH WOULD IMPEDE THE ABILITY OF A HEALTH CARE PLAN TO OBTAIN OR RETAIN ACCREDITATION BY THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE OR A SIMILAR BODY.
S 4922. FEE RELATED COLLECTIVE NEGOTIATION. 1. IF THE HEALTH CARE PLAN HAS SUBSTANTIAL MARKET SHARE IN A BUSINESS LINE IN ANY GEOGRAPHIC AREA FOR WHICH A NEGOTIATION HAS BEEN APPROVED BY THE COMMISSIONER, HEALTH CARE PROVIDERS PRACTICING WITHIN THAT GEOGRAPHIC AREA MAY COLLECTIVELY NEGOTIATE THE FOLLOWING TERMS AND CONDITIONS RELATING TO THAT BUSINESS LINE WITH THE HEALTH CARE PLAN:
(A) THE FEES ASSESSED BY THE HEALTH CARE PLAN FOR SERVICES, INCLUDING FEES ESTABLISHED THROUGH THE APPLICATION OF REIMBURSEMENT PROCEDURES;
(B) THE CONVERSION FACTORS USED BY THE HEALTH CARE PLAN 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;
(C) THE AMOUNT OF ANY DISCOUNT GRANTED BY THE HEALTH CARE PLAN ON THE FEE OF HEALTH CARE SERVICES TO BE RENDERED BY HEALTH CARE PROVIDERS;

(D) THE DOLLAR AMOUNT OF CAPITATION OR FIXED PAYMENT FOR HEALTH SERVICES RENDERED BY HEALTH CARE PROVIDERS TO HEALTH CARE PLAN ENROLLEES;

(E) THE PROCEDURE CODE OR OTHER DESCRIPTION OF A HEALTH CARE SERVICE COVERED BY A PAYMENT AND THE APPROPRIATE GROUPING OF THE PROCEDURE CODES; OR

(F) THE AMOUNT OF ANY OTHER COMPONENT OF THE REIMBURSEMENT METHODOLOGY FOR A HEALTH CARE SERVICE.

2. NOTHING HEREIN 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 4923. 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 CONTRACTUAL TERMS AND CONDITIONS TO BE NEGOTIATED WITH A HEALTH CARE PLAN;

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

(C) A HEALTH CARE PROVIDERS' REPRESENTATIVE IS THE ONLY PARTY AUTHORIZED TO NEGOTIATE WITH HEALTH CARE PLANS ON BEHALF OF THE HEALTH CARE PROVIDERS AS A GROUP;

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

(E) IN COMMUNICATING OR NEGOTIATING WITH THE HEALTH CARE PROVIDERS' REPRESENTATIVE, A HEALTH CARE PLAN IS ENTITLED TO CONTRACT WITH OR OFFER DIFFERENT CONTRACT TERMS AND CONDITIONS TO INDIVIDUAL COMPETING HEALTH CARE PROVIDERS.

2. A HEALTH CARE PROVIDERS' REPRESENTATIVE MAY NOT REPRESENT MORE THAN THIRTY PERCENT OF THE MARKET OF HEALTH CARE PROVIDERS OR OF A PARTICULAR HEALTH CARE PROVIDER TYPE OR SPECIALTY PRACTICING IN THE GEOGRAPHIC AREA FOR WHICH A NEGOTIATION HAS BEEN APPROVED BY THE COMMISSIONER IF THE HEALTH CARE PLAN COVERS LESS THAN FIVE PERCENT OF THE ACTUAL NUMBER OF COVERED LIVES OF THE HEALTH CARE PLAN IN THE AREA, AS DETERMINED BY THE DEPARTMENT.

3. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO PROHIBIT COLLECTIVE ACTION ON THE PART OF ANY HEALTH CARE PROVIDER WHO IS A MEMBER OF A COLLECTIVE BARGAINING UNIT RECOGNIZED PURSUANT TO THE NATIONAL LABOR RELATIONS ACT.

S 4924. REQUIREMENTS FOR HEALTH CARE PROVIDERS' REPRESENTATIVE. 1. BEFORE ENGAGING IN COLLECTIVE NEGOTIATIONS WITH A HEALTH CARE PLAN ON BEHALF OF HEALTH CARE PROVIDERS, A HEALTH CARE PROVIDERS' REPRESENTATIVE SHALL FILE WITH THE COMMISSIONER, IN THE MANNER PRESCRIBED BY THE COMMISSIONER, INFORMATION IDENTIFYING THE REPRESENTATIVE, THE REPRESENTATIVE'S PLAN OF OPERATION, AND THE REPRESENTATIVE'S PROCEDURES TO ENSURE COMPLIANCE WITH THIS TITLE.

2. BEFORE ENGAGING IN THE COLLECTIVE NEGOTIATIONS, THE HEALTH CARE PROVIDERS' REPRESENTATIVE SHALL ALSO SUBMIT TO THE COMMISSIONER FOR THE COMMISSIONER'S APPROVAL A REPORT IDENTIFYING THE PROPOSED SUBJECT MATTER OF THE NEGOTIATIONS OR DISCUSSIONS WITH THE HEALTH CARE PLAN AND THE EFFICIENCIES OR BENEFITS EXPECTED TO BE ACHIEVED THROUGH THE NEGOTIATIONS FOR BOTH THE PROVIDERS AND CONSUMERS OF HEALTH SERVICES. THE COMMISSIONER SHALL NOT APPROVE THE REPORT IF THE COMMISSIONER, IN CONSULTATION WITH THE SUPERINTENDENT OF FINANCIAL SERVICES DETERMINES THAT THE PROPOSED NEGOTIATIONS WOULD EXCEED THE AUTHORITY GRANTED UNDER THIS TITLE.

3. THE REPRESENTATIVE SHALL SUPPLEMENT THE INFORMATION IN THE REPORT ON A REGULAR BASIS OR AS NEW INFORMATION BECOMES AVAILABLE, INDICATING THAT THE SUBJECT MATTER OF THE NEGOTIATIONS WITH THE HEALTH CARE PLAN HAS CHANGED OR WILL CHANGE. IN NO EVENT SHALL THE REPORT BE LESS THAN EVERY THIRTY DAYS.

4. WITH THE ADVICE OF THE SUPERINTENDENT OF FINANCIAL SERVICES AND THE ATTORNEY GENERAL, THE COMMISSIONER SHALL APPROVE OR DISAPPROVE THE REPORT NOT LATER THAN THE TWENTIETH DAY AFTER THE DATE ON WHICH THE REPORT IS FILED. IF DISAPPROVED, THE COMMISSIONER SHALL FURNISH A WRITTEN EXPLANATION OF ANY DEFICIENCIES, ALONG WITH A STATEMENT OF SPECIFIC PROPOSALS FOR REMEDIAL MEASURES TO CURE THE DEFICIENCIES. IF THE COMMISSIONER DOES NOT SO ACT WITHIN THE TWENTY DAYS, THE REPORT SHALL BE DEEMED APPROVED.

5. A PERSON WHO ACTS AS A HEALTH CARE PROVIDERS' REPRESENTATIVE WITHOUT THE APPROVAL OF THE COMMISSIONER UNDER THIS SECTION SHALL BE DEEMED TO BE ACTING OUTSIDE THE AUTHORITY GRANTED UNDER THIS TITLE.

6. BEFORE REPORTING THE RESULTS OF NEGOTIATIONS WITH A HEALTH CARE PLAN OR PROVIDING TO THE AFFECTED HEALTH CARE PROVIDERS AN EVALUATION OF ANY OFFER MADE BY A HEALTH CARE PLAN, THE HEALTH CARE PROVIDERS' REPRESENTATIVE SHALL FURNISH FOR APPROVAL BY THE COMMISSIONER, BEFORE DISSEMINATION TO THE HEALTH CARE PROVIDERS, A COPY OF ALL COMMUNICATIONS TO BE MADE TO THE HEALTH CARE PROVIDERS RELATED TO NEGOTIATIONS, DISCUSSIONS, AND OFFERS MADE BY THE HEALTH CARE PLAN.

7. A HEALTH CARE PROVIDERS' REPRESENTATIVE SHALL REPORT THE END OF NEGOTIATIONS TO THE COMMISSIONER NOT LATER THAN THE FOURTEENTH DAY AFTER THE DATE OF A HEALTH CARE PLAN DECISION DECLINING NEGOTIATION, CANCELING NEGOTIATIONS, OR FAILING TO RESPOND TO A REQUEST FOR NEGOTIATION. IN SUCH INSTANCES, A HEALTH CARE PROVIDERS' REPRESENTATIVE MAY REQUEST INTERVENTION FROM THE COMMISSIONER TO REQUIRE THE HEALTH CARE PLAN TO PARTICIPATE IN THE NEGOTIATION PURSUANT TO SUBDIVISION EIGHT OF THIS SECTION.

8. (A) IN THE EVENT THE COMMISSIONER DETERMINES THAT AN IMPASSE EXISTS IN THE NEGOTIATIONS, OR IN THE EVENT A HEALTH CARE PLAN DECLINES TO NEGOTIATE, CANCELS NEGOTIATIONS OR FAILS TO RESPOND TO A REQUEST FOR NEGOTIATION, THE COMMISSIONER SHALL RENDER ASSISTANCE AS FOLLOWS:

(1) TO ASSIST THE PARTIES TO EFFECT A VOLUNTARY RESOLUTION OF THE NEGOTIATIONS, THE COMMISSIONER SHALL APPOINT A MEDIATOR FROM A LIST OF QUALIFIED PERSONS MAINTAINED BY THE COMMISSIONER. IF THE MEDIATOR IS SUCCESSFUL IN RESOLVING THE IMPASSE, THEN THE HEALTH CARE PROVIDERS' REPRESENTATIVE SHALL PROCEED AS SET FORTH IN THIS ARTICLE;

(2) IF AN IMPASSE CONTINUES, THE COMMISSIONER SHALL APPOINT A FACT-FINDING BOARD OF NOT MORE THAN THREE MEMBERS FROM A LIST OF QUALIFIED PERSONS MAINTAINED BY THE COMMISSIONER, WHICH FACT-FINDING BOARD SHALL HAVE, IN ADDITION TO THE POWERS DELEGATED TO IT BY THE BOARD, THE POWER TO MAKE RECOMMENDATIONS FOR THE RESOLUTION OF THE DISPUTE;

(B) THE FACT-FINDING BOARD, ACTING BY A MAJORITY OF ITS MEMBERS, SHALL TRANSMIT ITS FINDINGS OF FACT AND RECOMMENDATIONS FOR RESOLUTION OF THE DISPUTE TO THE COMMISSIONER, AND MAY THEREAFTER ASSIST THE PARTIES TO EFFECT A VOLUNTARY RESOLUTION OF THE DISPUTE. THE FACT-FINDING BOARD SHALL ALSO SHARE ITS FINDINGS OF FACT AND RECOMMENDATIONS WITH THE HEALTH CARE PROVIDERS' REPRESENTATIVE AND THE HEALTH CARE PLAN. IF WITHIN TWENTY DAYS AFTER THE SUBMISSION OF THE FINDINGS OF FACT AND RECOMMENDATIONS, THE IMPASSE CONTINUES, THE COMMISSIONER SHALL ORDER A RESOLUTION TO THE NEGOTIATIONS BASED UPON THE FINDINGS OF FACT AND RECOMMENDATIONS SUBMITTED BY THE FACT-FINDING BOARD.

9. ANY PROPOSED AGREEMENT BETWEEN HEALTH CARE PROVIDERS AND A HEALTH CARE PLAN NEGOTIATED PURSUANT TO THIS TITLE SHALL BE SUBMITTED TO THE COMMISSIONER FOR FINAL APPROVAL. THE COMMISSIONER SHALL APPROVE OR DISAPPROVE THE AGREEMENT WITHIN SIXTY DAYS OF SUCH SUBMISSION.

10. THE COMMISSIONER MAY COLLECT INFORMATION FROM OTHER PERSONS TO ASSIST IN EVALUATING THE IMPACT OF THE PROPOSED ARRANGEMENT ON THE HEALTH CARE MARKETPLACE. THE COMMISSIONER SHALL COLLECT INFORMATION FROM HEALTH PLAN COMPANIES AND HEALTH CARE PROVIDERS OPERATING IN THE SAME GEOGRAPHIC AREA.

S 4925. CERTAIN COLLECTIVE ACTION PROHIBITED. 1. THIS TITLE IS NOT INTENDED TO AUTHORIZE COMPETING HEALTH CARE PROVIDERS TO ACT IN CONCERT IN RESPONSE TO A REPORT ISSUED BY THE HEALTH CARE PROVIDERS' REPRESENTATIVE RELATED TO THE REPRESENTATIVE'S DISCUSSIONS OR NEGOTIATIONS WITH HEALTH CARE PLANS.

2. NO HEALTH CARE PROVIDERS' REPRESENTATIVE SHALL NEGOTIATE ANY AGREEMENT THAT EXCLUDES, LIMITS THE PARTICIPATION OR REIMBURSEMENT OF, OR OTHERWISE LIMITS THE SCOPE OF SERVICES TO BE PROVIDED BY ANY HEALTH CARE PROVIDER OR GROUP OF HEALTH CARE PROVIDERS WITH RESPECT TO THE PERFORMANCE OF SERVICES THAT ARE WITHIN THE HEALTH CARE PROVIDER'S SCOPE OF PRACTICE, LICENSE, REGISTRATION, OR CERTIFICATE.

S 4926. FEES. EACH PERSON WHO ACTS AS THE REPRESENTATIVE OR NEGOTIATING PARTIES UNDER THIS TITLE SHALL PAY TO THE DEPARTMENT A FEE TO ACT AS A REPRESENTATIVE. THE COMMISSIONER, BY RULE, SHALL SET FEES IN AMOUNTS DEEMED REASONABLE AND NECESSARY TO COVER THE COSTS INCURRED BY THE DEPARTMENT IN ADMINISTERING THIS TITLE. ANY FEE COLLECTED UNDER THIS SECTION SHALL BE DEPOSITED IN THE STATE TREASURY TO THE CREDIT OF THE GENERAL FUND/STATE OPERATIONS - 003 FOR THE NEW YORK STATE DEPARTMENT OF HEALTH FUND.

S 4927. MONITORING OF AGREEMENTS. THE COMMISSIONER SHALL ACTIVELY MONITOR AGREEMENTS APPROVED UNDER THIS TITLE TO ENSURE THAT THE AGREEMENT REMAINS IN COMPLIANCE WITH THE CONDITIONS OF APPROVAL. UPON REQUEST, A HEALTH CARE PLAN OR HEALTH CARE PROVIDER SHALL PROVIDE INFORMATION REGARDING COMPLIANCE. THE COMMISSIONER MAY REVOKE AN APPROVAL UPON A FINDING THAT THE AGREEMENT IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE TERMS OF THE APPLICATION OR THE CONDITIONS OF APPROVAL.

S 4928. CONFIDENTIALITY. ALL REPORTS AND OTHER INFORMATION REQUIRED TO BE REPORTED TO THE DEPARTMENT OF LAW UNDER THIS TITLE INCLUDING INFORMATION OBTAINED BY THE COMMISSIONER PURSUANT TO SUBDIVISION TEN OF SECTION FORTY-NINE HUNDRED TWENTY-FOUR OF THIS TITLE SHALL NOT BE SUBJECT TO DISCLOSURE UNDER ARTICLE SIX OF THE PUBLIC OFFICERS LAW OR ARTICLE THIRTY-ONE OF THE CIVIL PRACTICE LAW AND RULES.

S 4929. SEVERABILITY AND CONSTRUCTION. THE PROVISIONS OF THIS TITLE SHALL BE SEVERABLE, AND IF ANY COURT OF COMPETENT JURISDICTION DECLARES ANY PHRASE, CLAUSE, SENTENCE OR PROVISION OF THIS TITLE TO BE INVALID, OR ITS APPLICABILITY TO ANY GOVERNMENT, AGENCY, PERSON OR CIRCUMSTANCE IS DECLARED INVALID, THE REMAINDER OF THIS TITLE AND ITS RELEVANT APPLICABILITY SHALL NOT BE AFFECTED. THE PROVISIONS OF THIS TITLE SHALL BE LIBERALLY CONSTRUED TO GIVE EFFECT TO THE PURPOSES THEREOF.

S 4. This act shall take effect on the one hundred twentieth day after it shall have become a law; provided that the commissioner of health is authorized to promulgate any and all rules and regulations and take any other measures necessary to implement this act on its effective date on or before such date.