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11 S 4920. DEFINITIONS. FOR PURPOSES OF THIS TITLE:

12 1. "HEALTH CARE PLAN" MEANS AN ENTITY (OTHER THAN A HEALTH CARE
13 PROVIDER) THAT APPROVES, PROVIDES, ARRANGES FOR, OR PAYS FOR HEALTH CARE
14 SERVICES IN THE DEMONSTRATION SERVICE AREA, INCLUDING BUT NOT LIMITED
15 TO:16 (A) A HEALTH MAINTENANCE ORGANIZATION LICENSED PURSUANT TO ARTICLE
17 FORTY-THREE OF THE INSURANCE LAW OR CERTIFIED PURSUANT TO ARTICLE
18 FORTY-FOUR OF THIS CHAPTER;19 (B) ANY OTHER ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF
20 THIS CHAPTER; OR

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

22 2. "PERSON" MEANS AN INDIVIDUAL, ASSOCIATION, CORPORATION, OR ANY
23 OTHER LEGAL ENTITY.24 3. "HEALTH CARE PROVIDERS' REPRESENTATIVE" MEANS A THIRD PARTY WHO IS
25 AUTHORIZED BY HEALTH CARE PROVIDERS TO NEGOTIATE ON THEIR BEHALF WITH
26 HEALTH CARE PLANS OVER CONTRACTUAL TERMS AND CONDITIONS AFFECTING THOSE
27 HEALTH CARE PROVIDERS.28 4. "STRIKE" MEANS A WORK STOPPAGE IN PART OR IN WHOLE, DIRECT OR INDI-
29 RECT, BY A BODY OF WORKERS TO GAIN COMPLIANCE WITH DEMANDS MADE ON AN
30 EMPLOYER.31 5. "SUBSTANTIAL MARKET SHARE IN A BUSINESS LINE" EXISTS IF A HEALTH
32 CARE PLAN'S MARKET SHARE OF A BUSINESS LINE WITHIN THE DEMONSTRATION
33 SERVICE AREA AS APPROVED BY THE COMMISSIONER, IN CONSULTATION WITH THE
34 SUPERINTENDENT OF FINANCIAL SERVICES, ALONE OR IN COMBINATION WITH THE
35 MARKET SHARES OF AFFILIATES, EXCEEDS EITHER TEN PERCENT OF THE TOTAL
36 NUMBER OF COVERED LIVES IN THAT SERVICE AREA FOR SUCH BUSINESS LINE OR
37 TWENTY-FIVE THOUSAND LIVES, OR IF THE COMMISSIONER, IN CONSULTATION WITH
38 THE SUPERINTENDENT OF FINANCIAL SERVICES, DETERMINES THE MARKET SHARE OF
39 THE INSURER IN THE RELEVANT INSURANCE PRODUCT AND GEOGRAPHIC MARKETS FOR
40 THE SERVICES OF THE PROVIDERS SEEKING TO COLLECTIVELY NEGOTIATE SIGNIF-
41 ICANTLY EXCEEDS THE COUNTERVAILING MARKET SHARE OF THE PROVIDERS ACTING
42 INDIVIDUALLY.43 6. "HEALTH CARE PROVIDER" MEANS A PERSON WHO IS LICENSED, CERTIFIED,
44 OR REGISTERED PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW AND WHO PRAC-
45 TICES AS A HEALTH CARE PROVIDER AS AN INDEPENDENT CONTRACTOR AND/OR WHO
46 IS AN OWNER, OFFICER, SHAREHOLDER, OR PROPRIETOR OF A HEALTH CARE
47 PROVIDER IN THE DEMONSTRATION SERVICE AREA. A HEALTH CARE PROVIDER
48 UNDER TITLE EIGHT OF THE EDUCATION LAW WHO PRACTICES AS AN EMPLOYEE OF A
49 HEALTH CARE PROVIDER SHALL NOT BE DEEMED A HEALTH CARE PROVIDER FOR
50 PURPOSES OF THIS TITLE.51 7. "DEMONSTRATION SERVICE AREA" SHALL INCLUDE THE COUNTIES OF ALBANY,
52 COLUMBIA, GREENE, ORANGE, RENSSELAER, SARATOGA, SCHENECTADY, SCHOHARIE,
53 ULSTER, WARREN AND WASHINGTON.54 S 4921. NON-FEE RELATED COLLECTIVE NEGOTIATION AUTHORIZED. 1. HEALTH
55 CARE PROVIDERS PRACTICING WITHIN THE DEMONSTRATION SERVICE AREA MAY MEET
56 AND COMMUNICATE FOR THE PURPOSE OF COLLECTIVELY NEGOTIATING WITH A

1 HEALTH CARE PLAN THE FOLLOWING TERMS AND CONDITIONS OF PROVIDER
2 CONTRACTS WITH THE HEALTH CARE PLAN:

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

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

9 (C) THE DEFINITION OF MEDICAL NECESSITY;

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

12 (E) PREVENTIVE CARE AND OTHER MEDICAL MANAGEMENT PRACTICES;

13 (F) DRUG FORMULARIES AND STANDARDS AND PROCEDURES FOR PRESCRIBING
14 OFF-FORMULARY DRUGS;

15 (G) RESPECTIVE PHYSICIAN LIABILITY FOR THE TREATMENT OR LACK OF TREAT-
16 MENT OF COVERED PERSONS;

17 (H) THE DETAILS OF HEALTH CARE PLAN RISK TRANSFER ARRANGEMENTS WITH
18 PROVIDERS;

19 (I) PLAN ADMINISTRATIVE PROCEDURES, INCLUDING METHODS AND TIMING OF
20 HEALTH CARE PROVIDER PAYMENT FOR SERVICES;

21 (J) PROCEDURES TO BE UTILIZED TO RESOLVE DISPUTES BETWEEN THE HEALTH
22 CARE PLAN AND HEALTH CARE PROVIDERS;

23 (K) PATIENT REFERRAL PROCEDURES INCLUDING, BUT NOT LIMITED TO, THOSE
24 APPLICABLE TO OUT-OF-POCKET NETWORK REFERRALS;

25 (L) THE FORMULATION AND APPLICATION OF HEALTH CARE PROVIDER REIMBURSE-
26 MENT PROCEDURES;

27 (M) QUALITY ASSURANCE PROGRAMS;

28 (N) THE PROCESS FOR RENDERING UTILIZATION REVIEW DETERMINATIONS
29 INCLUDING: ESTABLISHMENT OF A PROCESS FOR RENDERING UTILIZATION REVIEW
30 DETERMINATIONS WHICH SHALL, AT A MINIMUM, INCLUDE: WRITTEN PROCEDURES TO
31 ASSURE THAT UTILIZATION REVIEWS AND DETERMINATIONS ARE CONDUCTED WITHIN
32 THE TIMEFRAMES ESTABLISHED IN THIS ARTICLE; PROCEDURES TO NOTIFY AN
33 ENROLLEE, AN ENROLLEE'S DESIGNEE AND/OR AN ENROLLEE'S HEALTH CARE
34 PROVIDER OF ADVERSE DETERMINATIONS; AND PROCEDURES FOR APPEAL OF ADVERSE
35 DETERMINATIONS, INCLUDING THE ESTABLISHMENT OF AN EXPEDITED APPEALS
36 PROCESS FOR DENIALS OF CONTINUED INPATIENT CARE OR WHERE THERE IS IMMI-
37 NENT OR SERIOUS THREAT TO THE HEALTH OF THE ENROLLEE; AND

38 (O) HEALTH CARE PROVIDER SELECTION AND TERMINATION CRITERIA USED BY
39 THE HEALTH CARE PLAN.

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

43 3. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO ALLOW A STRIKE OF A
44 HEALTH CARE PLAN BY HEALTH CARE PROVIDERS OR PLANS AS OTHERWISE SET
45 FORTH IN THE LAWS OF THIS STATE.

46 4. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO ALLOW OR AUTHORIZE
47 TERMS OR CONDITIONS WHICH WOULD IMPEDE THE ABILITY OF A HEALTH CARE PLAN
48 TO OBTAIN OR RETAIN ACCREDITATION BY THE NATIONAL COMMITTEE FOR QUALITY
49 ASSURANCE OR A SIMILAR BODY.

50 S 4922. FEE RELATED COLLECTIVE NEGOTIATION. 1. IF THE HEALTH CARE PLAN
51 HAS SUBSTANTIAL MARKET SHARE IN A BUSINESS LINE IN THE DEMONSTRATION
52 SERVICE AREA, HEALTH CARE PROVIDERS PRACTICING WITHIN THE DEMONSTRATION
53 SERVICE AREA MAY COLLECTIVELY NEGOTIATE THE FOLLOWING TERMS AND CONDI-
54 TIONS RELATING TO THAT BUSINESS LINE WITH THE HEALTH CARE PLAN:

55 (A) THE FEES ASSESSED BY THE HEALTH CARE PLAN FOR SERVICES, INCLUDING
56 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 DEMONSTRATION SERVICE AREA OR PROPOSED SERVICE AREA OF A HEALTH CARE PLAN THAT COVERS LESS THAN FIVE PERCENT OF THE ACTUAL NUMBER OF COVERED LIVES OF THE HEALTH CARE PLAN IN THE DEMONSTRATION SERVICE 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 NEGOTI-

1 ATIONS FOR BOTH THE PROVIDERS AND CONSUMERS OF HEALTH SERVICES. THE
2 COMMISSIONER SHALL NOT APPROVE THE REPORT IF THE COMMISSIONER, IN
3 CONSULTATION WITH THE SUPERINTENDENT OF FINANCIAL SERVICES, DETERMINES
4 THAT THE PROPOSED NEGOTIATIONS WOULD EXCEED THE AUTHORITY GRANTED UNDER
5 THIS TITLE.

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

11 4. WITH THE ADVICE OF THE SUPERINTENDENT OF FINANCIAL SERVICES, THE
12 COMMISSIONER SHALL APPROVE OR DISAPPROVE THE REPORT NOT LATER THAN THE
13 TWENTIETH DAY AFTER THE DATE ON WHICH THE REPORT IS FILED. IF DISAP-
14 PROVED, THE COMMISSIONER SHALL FURNISH A WRITTEN EXPLANATION OF ANY
15 DEFICIENCIES, ALONG WITH A STATEMENT OF SPECIFIC PROPOSALS FOR REMEDIAL
16 MEASURES TO CURE THE DEFICIENCIES. IF THE COMMISSIONER DOES NOT SO ACT
17 WITHIN THE TWENTY DAYS, THE REPORT SHALL BE DEEMED APPROVED.

18 5. A PERSON WHO ACTS AS A HEALTH CARE PROVIDERS' REPRESENTATIVE WITH-
19 OUT THE APPROVAL OF THE COMMISSIONER UNDER THIS SECTION SHALL BE DEEMED
20 TO BE ACTING OUTSIDE THE AUTHORITY GRANTED UNDER THIS TITLE.

21 6. BEFORE REPORTING THE RESULTS OF NEGOTIATIONS WITH A HEALTH CARE
22 PLAN OR PROVIDING TO THE AFFECTED HEALTH CARE PROVIDERS AN EVALUATION OF
23 ANY OFFER MADE BY A HEALTH CARE PLAN, THE HEALTH CARE PROVIDERS' REPRE-
24 SENTATIVE SHALL FURNISH FOR APPROVAL BY THE COMMISSIONER, BEFORE DISSEM-
25 INATION TO THE HEALTH CARE PROVIDERS, A COPY OF ALL COMMUNICATIONS TO BE
26 MADE TO THE HEALTH CARE PROVIDERS RELATED TO NEGOTIATIONS, DISCUSSIONS,
27 AND OFFERS MADE BY THE HEALTH CARE PLAN.

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

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

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

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

50 (B) THE FACT-FINDING BOARD, ACTING BY A MAJORITY OF ITS MEMBERS, SHALL
51 TRANSMIT ITS FINDINGS OF FACT AND RECOMMENDATIONS FOR RESOLUTION OF THE
52 DISPUTE TO THE COMMISSIONER, AND MAY THEREAFTER ASSIST THE PARTIES TO
53 EFFECT A VOLUNTARY RESOLUTION OF THE DISPUTE. THE FACT-FINDING BOARD
54 SHALL ALSO SHARE ITS FINDINGS OF FACT AND RECOMMENDATIONS WITH THE
55 HEALTH CARE PROVIDERS' REPRESENTATIVE AND THE HEALTH CARE PLAN. IF WITH-
56 IN TWENTY DAYS AFTER THE SUBMISSION OF THE FINDINGS OF FACT AND RECOM-

1 MENDATIONS, THE IMPASSE CONTINUES, THE COMMISSIONER SHALL ORDER A RESOL-
2 UTION TO THE NEGOTIATIONS BASED UPON THE FINDINGS OF FACT AND
3 RECOMMENDATIONS SUBMITTED BY THE FACT-FINDING BOARD.

4 9. ANY PROPOSED AGREEMENT BETWEEN HEALTH CARE PROVIDERS AND A HEALTH
5 CARE PLAN NEGOTIATED PURSUANT TO THIS TITLE SHALL BE SUBMITTED TO THE
6 COMMISSIONER FOR FINAL APPROVAL. THE COMMISSIONER SHALL APPROVE OR
7 DISAPPROVE THE AGREEMENT WITHIN SIXTY DAYS OF SUCH SUBMISSION. THE
8 COMMISSIONER, AFTER CONSULTATION WITH THE SUPERINTENDENT OF FINANCIAL
9 SERVICES SHALL DISAPPROVE THE AGREEMENT IF HE OR SHE FINDS THAT THE
10 AGREEMENT WOULD RESULT IN A SIGNIFICANT INCREASE IN COSTS TO THE MEDI-
11 CAID MANAGED CARE PROGRAM PURSUANT TO SECTION THREE HUNDRED SIXTY-FOUR-J
12 OF THE SOCIAL SERVICES LAW, THE FAMILY HEALTH PLUS PROGRAM PURSUANT TO
13 SECTION THREE HUNDRED SIXTY-NINE-EE OF THE SOCIAL SERVICES LAW, OR THE
14 CHILD HEALTH PLUS PROGRAM PURSUANT TO SECTION TWENTY-FIVE HUNDRED ELEVEN
15 OF THE PUBLIC HEALTH LAW.

16 10. THE COMMISSIONER MAY COLLECT INFORMATION FROM THE DEPARTMENT OF
17 FINANCIAL SERVICES AND OTHER PERSONS TO ASSIST IN EVALUATING THE IMPACT
18 OF THE PROPOSED ARRANGEMENT ON THE HEALTH CARE MARKETPLACE. THE COMMIS-
19 SIONER SHALL COLLECT INFORMATION FROM HEALTH PLAN COMPANIES AND HEALTH
20 CARE PROVIDERS OPERATING IN THE SAME GEOGRAPHIC AREA AS THE HEALTH CARE
21 COOPERATIVE.

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

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

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

41 S 4927. MONITORING OF AGREEMENTS. THE COMMISSIONER SHALL ACTIVELY
42 MONITOR AGREEMENTS APPROVED UNDER THIS TITLE TO ENSURE THAT THE AGREE-
43 MENT REMAINS IN COMPLIANCE WITH THE CONDITIONS OF APPROVAL. UPON
44 REQUEST, A HEALTH CARE PLAN OR HEALTH CARE PROVIDER SHALL PROVIDE INFOR-
45 MATION REGARDING COMPLIANCE. THE COMMISSIONER MAY REVOKE AN APPROVAL
46 UPON A FINDING THAT THE AGREEMENT IS NOT IN SUBSTANTIAL COMPLIANCE WITH
47 THE TERMS OF THE APPLICATION OR THE CONDITIONS OF APPROVAL.

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

54 S 4929. SEVERABILITY AND CONSTRUCTION. THE PROVISIONS OF THIS TITLE
55 SHALL BE SEVERABLE, AND IF ANY COURT OF COMPETENT JURISDICTION DECLARES
56 ANY PHRASE, CLAUSE, SENTENCE OR PROVISION OF THIS TITLE TO BE INVALID,

1 OR ITS APPLICABILITY TO ANY GOVERNMENT, AGENCY, PERSON OR CIRCUMSTANCE
2 IS DECLARED INVALID, THE REMAINDER OF THIS TITLE AND ITS RELEVANT APPLI-
3 CABILITY SHALL NOT BE AFFECTED. THE PROVISIONS OF THIS TITLE SHALL BE
4 LIBERALLY CONSTRUED TO GIVE EFFECT TO THE PURPOSES THEREOF.

5 S 4. The department of health, in consultation with the department of
6 financial services, shall prepare or shall arrange for the preparation
7 of a report on the implementation of the demonstration program on
8 collective negotiation. The report shall be submitted to the governor,
9 the speaker of the assembly, the temporary president of the senate and
10 the chairs of the senate and assembly health and insurance committees at
11 least four months prior to the expiration of this act. The report shall
12 review the extent to which collective negotiations were conducted in the
13 demonstration service area and shall examine whether and the extent to
14 which collective negotiation contributed to the improvement of quality
15 of care for patients, enhanced access to medically necessary care,
16 reduced unnecessary health care expenditures, and was otherwise in the
17 public interest. The report may make recommendations regarding the
18 extension, alteration and/or expansion of these provisions and make any
19 other recommendations related to the implementation of collective nego-
20 tiation pursuant to this act.

21 S 5. This act shall take effect on the one hundred twentieth day after
22 it shall have become a law and shall expire and be deemed repealed three
23 years after it shall take effect; provided that the commissioner of
24 health is authorized to promulgate any and all rules and regulations and
25 take any other measures necessary to implement this act on its effective
26 date on or before such date.