

3525

2015-2016 Regular Sessions

I N S E N A T E

February 11, 2015

Introduced by Sens. PERKINS, ADDABBO, AVELLA, BRESLIN, DILAN, ESPAILLAT, HASSELL-THOMPSON, HOYLMAN, KRUEGER, LATIMER, MONTGOMERY, PARKER, PERALTA, RIVERA, SAMPSON, SANDERS, SERRANO, SQUADRON, STAVISKY -- read twice and ordered printed, and when printed to be committed to the Committee on Health

AN ACT to amend the public health law and the state finance law, in relation to enacting the "New York health act" and 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. Short title. This act shall be known and may be cited as
2 the "New York health act".
3 S 2. Legislative findings and intent. 1. The state constitution
4 states: "The protection and promotion of the health of the inhabitants
5 of the state are matters of public concern and provision therefor shall
6 be made by the state and by such of its subdivisions and in such manner,
7 and by such means as the legislature shall from time to time determine."
8 (Article XVII, S3.) The legislature finds and declares that all resi-
9 dents of the state have the right to health care. While the federal
10 Affordable Care Act brought many improvements in health care and health
11 coverage, it still leaves many New Yorkers without coverage or with
12 inadequate coverage. New Yorkers - as individuals, employers, and
13 taxpayers - have experienced a rise in the cost of health care and
14 coverage in recent years, including rising premiums, deductibles and
15 co-pays, restricted provider networks and high out-of-network charges.
16 Businesses have also experienced increases in the costs of health care
17 benefits for their employees, and many employers are shifting a larger
18 share of the cost of coverage to their employees or dropping coverage
19 entirely. Health care providers are also affected by inadequate health
20 coverage in New York state. A large portion of voluntary and public
21 hospitals, health centers and other providers now experience substantial

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

LBD07764-02-5

1 losses due to the provision of care that is uncompensated. Individuals
2 often find that they are deprived of affordable care and choice because
3 of decisions by health plans guided by the plan's economic needs rather
4 than their health care needs. To address the fiscal crisis facing the
5 health care system and the state and to assure New Yorkers can exercise
6 their right to health care, affordable and comprehensive health coverage
7 must be provided. Pursuant to the state constitution's charge to the
8 legislature to provide for the health of New Yorkers, this legislation
9 is an enactment of state concern for the purpose of establishing a
10 comprehensive universal single-payer health care coverage program and a
11 health care cost control system for the benefit of all residents of the
12 state of New York.

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

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

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

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

53 S 3. Article 50 and sections 5000, 5001, 5002 and 5003 of the public
54 health law are renumbered article 80 and sections 8000, 8001, 8002 and
55 8003, respectively, and a new article 51 is added to read as follows:

ARTICLE 51
NEW YORK HEALTH

SECTION 5100. DEFINITIONS.

5101. PROGRAM CREATED.

5102. BOARD OF TRUSTEES.

5103. ELIGIBILITY AND ENROLLMENT.

5104. BENEFITS.

5105. HEALTH CARE PROVIDERS; CARE COORDINATION; PAYMENT METHODOLOGIES.

5106. HEALTH CARE ORGANIZATIONS.

5107. PROGRAM STANDARDS.

5108. REGULATIONS.

5109. PROVISIONS RELATING TO FEDERAL HEALTH PROGRAMS.

5110. ADDITIONAL PROVISIONS.

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

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

2. "CARE COORDINATION" MEANS SERVICES PROVIDED BY A CARE COORDINATOR UNDER SUBDIVISION TWO OF SECTION FIFTY-ONE HUNDRED FIVE OF THIS ARTICLE.

3. "CARE COORDINATOR" MEANS AN INDIVIDUAL OR ENTITY APPROVED TO PROVIDE CARE COORDINATION UNDER SUBDIVISION TWO OF SECTION FIFTY-ONE HUNDRED FIVE OF THIS ARTICLE.

4. "FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM" MEANS THE MEDICAL ASSISTANCE PROGRAM UNDER TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW, THE BASIC HEALTH PROGRAM UNDER SECTION THREE HUNDRED SIXTY-NINE-GG OF THE SOCIAL SERVICES LAW, AND THE CHILD HEALTH PLUS PROGRAM UNDER TITLE ONE-A OF ARTICLE TWENTY-FIVE OF THIS CHAPTER.

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

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

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

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

9. "MEDICAID" OR "MEDICAL ASSISTANCE" MEANS TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW AND THE PROGRAM THEREUNDER. "CHILD HEALTH PLUS" MEANS TITLE ONE-A OF ARTICLE TWENTY-FIVE OF THIS CHAPTER AND THE PROGRAM THEREUNDER. "MEDICARE" MEANS TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT AND THE PROGRAMS THEREUNDER. "BASIC HEALTH PROGRAM" MEANS SECTION THREE HUNDRED SIXTY-NINE-GG OF THE SOCIAL SERVICES LAW AND THE PROGRAM THEREUNDER.

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

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

12. "OUT-OF-STATE HEALTH CARE SERVICE" MEANS A HEALTH CARE SERVICE PROVIDED TO A MEMBER WHILE THE MEMBER IS OUT OF THE STATE AND (A) IT IS MEDICALLY NECESSARY THAT THE HEALTH CARE SERVICE BE PROVIDED WHILE THE MEMBER IS OUT OF THE STATE, OR (B) IT IS CLINICALLY APPROPRIATE THAT THE

HEALTH CARE SERVICE BE PROVIDED BY A PARTICULAR HEALTH CARE PROVIDER LOCATED OUT OF THE STATE RATHER THAN IN THE STATE.

13. "PARTICIPATING PROVIDER" MEANS ANY INDIVIDUAL OR ENTITY THAT IS A HEALTH CARE PROVIDER QUALIFIED UNDER SUBDIVISION THREE OF SECTION FIFTY-ONE HUNDRED FIVE OF THIS ARTICLE THAT PROVIDES HEALTH CARE SERVICES TO MEMBERS UNDER THE PROGRAM, OR A HEALTH CARE ORGANIZATION.

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

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

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

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

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

S 5101. PROGRAM CREATED. 1. THE NEW YORK HEALTH PROGRAM IS HEREBY CREATED IN THE DEPARTMENT. THE COMMISSIONER SHALL ESTABLISH AND IMPLEMENT THE PROGRAM UNDER THIS ARTICLE. THE PROGRAM SHALL PROVIDE COMPREHENSIVE HEALTH COVERAGE TO EVERY RESIDENT WHO ENROLLS IN THE PROGRAM.

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

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

4. AN INSURER AUTHORIZED TO PROVIDE COVERAGE PURSUANT TO THE INSURANCE LAW OR A HEALTH MAINTENANCE ORGANIZATION CERTIFIED UNDER THIS CHAPTER MAY, IF OTHERWISE AUTHORIZED, OFFER BENEFITS THAT DO NOT COVER ANY SERVICE FOR WHICH COVERAGE IS OFFERED TO INDIVIDUALS UNDER THE PROGRAM, BUT MAY NOT OFFER BENEFITS THAT COVER ANY SERVICE FOR WHICH COVERAGE IS OFFERED TO INDIVIDUALS UNDER THE PROGRAM. PROVIDED, HOWEVER, THAT THIS SUBDIVISION SHALL NOT PROHIBIT (A) THE OFFERING OF ANY BENEFITS TO OR FOR INDIVIDUALS, INCLUDING THEIR FAMILIES, WHO ARE EMPLOYED OR SELF-EMPLOYED IN THE STATE BUT WHO ARE NOT RESIDENTS OF THE STATE, OR (B) THE OFFERING OF BENEFITS DURING THE IMPLEMENTATION PERIOD TO INDIVIDUALS WHO ENROLLED OR MAY ENROLL AS MEMBERS OF THE PROGRAM, OR (C) THE OFFERING OF RETIREE HEALTH BENEFITS.

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

6. TO THE EXTENT ANY PROVISION OF THIS CHAPTER, THE SOCIAL SERVICES LAW OR THE INSURANCE LAW:

(A) IS INCONSISTENT WITH ANY PROVISION OF THIS ARTICLE OR THE LEGISLATIVE INTENT OF THE NEW YORK HEALTH ACT, THIS ARTICLE SHALL APPLY AND PREVAIL, EXCEPT WHERE EXPLICITLY PROVIDED OTHERWISE BY THIS ARTICLE; AND

(B) IS CONSISTENT WITH THE PROVISIONS OF THIS ARTICLE AND THE LEGISLATIVE INTENT OF THE NEW YORK HEALTH ACT, THE PROVISION OF THAT LAW SHALL APPLY.

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

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

(C) EIGHT TRUSTEES APPOINTED BY THE GOVERNOR; THREE TO BE APPOINTED ON THE RECOMMENDATION OF THE SPEAKER OF THE ASSEMBLY; THREE TO BE APPOINTED ON THE RECOMMENDATION OF THE TEMPORARY PRESIDENT OF THE SENATE; ONE TO BE APPOINTED ON THE RECOMMENDATION OF THE MINORITY LEADER OF THE ASSEMBLY; AND ONE TO BE APPOINTED ON THE RECOMMENDATION OF THE MINORITY LEADER OF THE SENATE.

3. 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.

4. 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

1 ESTABLISH AN EXECUTIVE COMMITTEE TO EXERCISE ANY POWERS OR DUTIES OF THE
2 BOARD AS IT MAY PROVIDE, AND OTHER COMMITTEES TO ASSIST THE BOARD OR THE
3 EXECUTIVE COMMITTEE. THE CHAIR OF THE BOARD SHALL CHAIR THE EXECUTIVE
4 COMMITTEE AND SHALL APPOINT THE CHAIR AND MEMBERS OF ALL OTHER COMMIT-
5 TEES. THE BOARD OF TRUSTEES MAY APPOINT ONE OR MORE ADVISORY COMMITTEES.
6 MEMBERS OF ADVISORY COMMITTEES NEED NOT BE MEMBERS OF THE BOARD OF TRUS-
7 TEES.

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

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

15 7. THE BOARD AND ITS COMMITTEES AND ADVISORY COMMITTEES MAY REQUEST
16 AND RECEIVE THE ASSISTANCE OF THE DEPARTMENT AND ANY OTHER STATE OR
17 LOCAL GOVERNMENTAL ENTITY IN EXERCISING ITS POWERS AND DUTIES.

18 8. NO LATER THAN TWO YEARS AFTER THE EFFECTIVE DATE OF THIS ARTICLE:

19 (A) THE BOARD SHALL DEVELOP A PROPOSAL, CONSISTENT WITH THE PRINCIPLES
20 OF THIS ARTICLE, FOR PROVISION BY THE PROGRAM OF LONG-TERM CARE COVER-
21 AGE, INCLUDING THE DEVELOPMENT OF A PROPOSAL, CONSISTENT WITH THE PRIN-
22 CIPLES OF THIS ARTICLE, FOR ITS FUNDING. IN DEVELOPING THE PROPOSAL,
23 THE BOARD SHALL CONSULT WITH AN ADVISORY COMMITTEE, APPOINTED BY THE
24 CHAIR OF THE BOARD, INCLUDING REPRESENTATIVES OF CONSUMERS AND POTENTIAL
25 CONSUMERS OF LONG-TERM CARE, PROVIDERS OF LONG-TERM CARE, LABOR, AND
26 OTHER INTERESTED PARTIES. THE BOARD SHALL PRESENT ITS PROPOSAL TO THE
27 GOVERNOR AND THE LEGISLATURE.

28 (B) THE BOARD SHALL DEVELOP PROPOSALS FOR: (I) INCORPORATING RETIREE
29 HEALTH BENEFITS INTO NEW YORK HEALTH; (II) ACCOMMODATING EMPLOYER RETI-
30 REE HEALTH BENEFITS FOR PEOPLE WHO HAVE BEEN MEMBERS OF NEW YORK HEALTH
31 BUT LIVE AS RETIREES OUT OF THE STATE; AND (III) ACCOMMODATING EMPLOYER
32 RETIREE HEALTH BENEFITS FOR PEOPLE WHO EARNED OR ACCRUED SUCH BENEFITS
33 WHILE RESIDING IN THE STATE PRIOR TO THE IMPLEMENTATION OF NEW YORK
34 HEALTH AND LIVE AS RETIREES OUT OF THE STATE.

35 (C) THE BOARD SHALL DEVELOP A PROPOSAL FOR NEW YORK HEALTH COVERAGE OF
36 HEALTH CARE SERVICES COVERED UNDER THE WORKERS' COMPENSATION LAW,
37 INCLUDING WHETHER AND HOW TO CONTINUE FUNDING FOR THOSE SERVICES UNDER
38 THAT LAW AND WHETHER AND HOW TO INCORPORATE AN ELEMENT OF EXPERIENCE
39 RATING.

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

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

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

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

50 (B) MEDICAID;

51 (C) MEDICARE;

52 (D) ARTICLE FORTY-FOUR OF THIS CHAPTER OR ARTICLE THIRTY-TWO OR
53 FORTY-THREE OF THE INSURANCE LAW;

54 (E) ARTICLE ELEVEN OF THE CIVIL SERVICE LAW, AS OF THE DATE ONE YEAR
55 BEFORE THE BEGINNING OF THE IMPLEMENTATION PERIOD;

(F) ANY COST INCURRED DEFINED IN PARAGRAPH ONE OF SUBSECTION (A) OF SECTION FIFTY-ONE HUNDRED TWO OF THE INSURANCE LAW, PROVIDED THAT THIS COVERAGE SHALL NOT REPLACE COVERAGE UNDER ARTICLE FIFTY-ONE OF THE INSURANCE LAW;

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

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

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

3. THE PROGRAM SHALL PROVIDE FOR PAYMENT UNDER THE PROGRAM FOR EMERGENCY AND TEMPORARY HEALTH CARE SERVICES PROVIDED TO MEMBERS OR INDIVIDUALS ENTITLED TO BECOME MEMBERS WHO HAVE NOT HAD A REASONABLE OPPORTUNITY TO BECOME A MEMBER OR TO ENROLL WITH A CARE COORDINATOR.

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

(B) A MEMBER MAY CHOOSE TO RECEIVE HEALTH CARE SERVICES UNDER THE PROGRAM FROM ANY PARTICIPATING PROVIDER, CONSISTENT WITH PROVISIONS OF THIS ARTICLE RELATING TO CARE COORDINATION AND HEALTH CARE ORGANIZATIONS, 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) 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.

(B) 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;

(III) A HEALTH CARE ORGANIZATION;

(IV) A TAFT-HARTLEY FUND, WITH RESPECT TO ITS MEMBERS AND THEIR FAMILY MEMBERS; PROVIDED THAT THIS PROVISION SHALL NOT PRECLUDE A TAFT-HARTLEY FUND FROM BECOMING A CARE COORDINATOR UNDER SUBPARAGRAPH (V) OF THIS

1 PARAGRAPH OR A HEALTH CARE ORGANIZATION UNDER SECTION FIFTY-ONE HUNDRED
2 SIX OF THIS ARTICLE; OR

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

4 (C) HEALTH CARE SERVICES PROVIDED TO A MEMBER SHALL NOT BE SUBJECT TO
5 PAYMENT UNDER THE PROGRAM UNLESS THE MEMBER IS ENROLLED WITH A CARE
6 COORDINATOR AT THE TIME THE HEALTH CARE SERVICE IS PROVIDED, EXCEPT
7 WHERE PROVIDED UNDER SUBDIVISION THREE OF SECTION FIFTY-ONE HUNDRED FOUR
8 OF THIS ARTICLE. EVERY MEMBER SHALL ENROLL WITH A CARE COORDINATOR THAT
9 AGREES TO PROVIDE CARE COORDINATION TO THE MEMBER PRIOR TO RECEIVING
10 HEALTH CARE SERVICES TO BE PAID FOR UNDER THE PROGRAM. THE MEMBER SHALL
11 REMAIN ENROLLED WITH THAT CARE COORDINATOR UNTIL THE MEMBER BECOMES
12 ENROLLED WITH A DIFFERENT CARE COORDINATOR OR CEASES TO BE A MEMBER.
13 MEMBERS HAVE THE RIGHT TO CHANGE THEIR CARE COORDINATOR ON TERMS AT
14 LEAST AS PERMISSIVE AS THE PROVISIONS OF SECTION THREE HUNDRED
15 SIXTY-FOUR-J OF THE SOCIAL SERVICES LAW RELATING TO AN INDIVIDUAL CHANG-
16 ING HIS OR HER PRIMARY CARE PROVIDER OR MANAGED CARE PROVIDER.

17 (D) CARE COORDINATION SHALL BE PROVIDED TO THE MEMBER BY THE MEMBER'S
18 CARE COORDINATOR. A CARE COORDINATOR MAY EMPLOY OR UTILIZE THE SERVICES
19 OF OTHER INDIVIDUALS OR ENTITIES TO ASSIST IN PROVIDING CARE COORDI-
20 NATION FOR THE MEMBER, CONSISTENT WITH REGULATIONS OF THE COMMISSIONER.

21 (E) A HEALTH CARE ORGANIZATION MAY ESTABLISH RULES RELATING TO CARE
22 COORDINATION FOR MEMBERS IN THE HEALTH CARE ORGANIZATION, DIFFERENT FROM
23 THIS SUBDIVISION BUT OTHERWISE CONSISTENT WITH THIS ARTICLE AND OTHER
24 APPLICABLE LAWS. NOTHING IN THIS SUBDIVISION SHALL AUTHORIZE ANY INDIV-
25 VIDUAL TO ENGAGE IN ANY ACT IN VIOLATION OF TITLE EIGHT OF THE EDUCATION
26 LAW.

27 (F) THE COMMISSIONER SHALL DEVELOP AND IMPLEMENT PROCEDURES AND STAND-
28 ARDS FOR AN INDIVIDUAL OR ENTITY TO BE APPROVED TO BE A CARE COORDINATOR
29 IN THE PROGRAM, INCLUDING BUT NOT LIMITED TO PROCEDURES AND STANDARDS
30 RELATING TO THE REVOCATION, SUSPENSION, LIMITATION, OR ANNULMENT OF
31 APPROVAL ON A DETERMINATION THAT THE INDIVIDUAL OR ENTITY IS INCOMPETENT
32 TO BE A CARE COORDINATOR OR HAS EXHIBITED A COURSE OF CONDUCT WHICH IS
33 EITHER INCONSISTENT WITH PROGRAM STANDARDS AND REGULATIONS OR WHICH
34 EXHIBITS AN UNWILLINGNESS TO MEET SUCH STANDARDS AND REGULATIONS, OR IS
35 A POTENTIAL THREAT TO THE PUBLIC HEALTH OR SAFETY. SUCH PROCEDURES AND
36 STANDARDS SHALL NOT LIMIT APPROVAL TO BE A CARE COORDINATOR IN THE
37 PROGRAM FOR ECONOMIC PURPOSES AND SHALL BE CONSISTENT WITH GOOD PROFES-
38 SIONAL PRACTICE. IN DEVELOPING THE PROCEDURES AND STANDARDS, THE COMMIS-
39 SIONER SHALL: (I) CONSIDER EXISTING STANDARDS DEVELOPED BY NATIONAL
40 ACCREDITING AND PROFESSIONAL ORGANIZATIONS; AND (II) CONSULT WITH
41 NATIONAL AND LOCAL ORGANIZATIONS WORKING ON CARE COORDINATION OR SIMILAR
42 MODELS, INCLUDING HEALTH CARE PRACTITIONERS, HOSPITALS, CLINICS, AND
43 CONSUMERS AND THEIR REPRESENTATIVES. WHEN DEVELOPING AND IMPLEMENTING
44 STANDARDS OF APPROVAL OF CARE COORDINATORS FOR INDIVIDUALS RECEIVING
45 CHRONIC MENTAL HEALTH CARE SERVICES, THE COMMISSIONER SHALL CONSULT WITH
46 THE COMMISSIONER OF MENTAL HEALTH. AN INDIVIDUAL OR ENTITY MAY NOT BE A
47 CARE COORDINATOR UNLESS THE SERVICES INCLUDED IN CARE COORDINATION ARE
48 WITHIN THE INDIVIDUAL'S PROFESSIONAL SCOPE OF PRACTICE OR THE ENTITY'S
49 LEGAL AUTHORITY.

50 (G) TO MAINTAIN APPROVAL UNDER THE PROGRAM, A CARE COORDINATOR MUST:
51 (I) RENEW ITS STATUS AT A FREQUENCY DETERMINED BY THE COMMISSIONER; AND
52 (II) PROVIDE DATA TO THE DEPARTMENT AS REQUIRED BY THE COMMISSIONER TO
53 ENABLE THE COMMISSIONER TO EVALUATE THE IMPACT OF CARE COORDINATORS ON
54 QUALITY, OUTCOMES AND COST.

55 3. HEALTH CARE PROVIDERS. (A) THE COMMISSIONER SHALL ESTABLISH AND
56 MAINTAIN PROCEDURES AND STANDARDS FOR HEALTH CARE PROVIDERS TO BE QUALI-

1 FIED TO PARTICIPATE IN THE PROGRAM, INCLUDING BUT NOT LIMITED TO PROCE-
2 DURES AND STANDARDS RELATING TO THE REVOCATION, SUSPENSION, LIMITATION,
3 OR ANNULMENT OF QUALIFICATION TO PARTICIPATE ON A DETERMINATION THAT THE
4 HEALTH CARE PROVIDER IS AN INCOMPETENT PROVIDER OF SPECIFIC HEALTH CARE
5 SERVICES OR HAS EXHIBITED A COURSE OF CONDUCT WHICH IS EITHER INCONSIST-
6 ENT WITH PROGRAM STANDARDS AND REGULATIONS OR WHICH EXHIBITS AN UNWILL-
7 INGNESS TO MEET SUCH STANDARDS AND REGULATIONS, OR IS A POTENTIAL THREAT
8 TO THE PUBLIC HEALTH OR SAFETY. SUCH PROCEDURES AND STANDARDS SHALL NOT
9 LIMIT HEALTH CARE PROVIDER PARTICIPATION IN THE PROGRAM FOR ECONOMIC
10 PURPOSES AND SHALL BE CONSISTENT WITH GOOD PROFESSIONAL PRACTICE. ANY
11 HEALTH CARE PROVIDER WHO IS QUALIFIED TO PARTICIPATE UNDER MEDICAID,
12 CHILD HEALTH PLUS OR MEDICARE SHALL BE DEEMED TO BE QUALIFIED TO PARTIC-
13 IPATE IN THE PROGRAM, AND ANY HEALTH CARE PROVIDER'S REVOCATION, SUSPEN-
14 SION, LIMITATION, OR ANNULMENT OF QUALIFICATION TO PARTICIPATE IN ANY OF
15 THOSE PROGRAMS SHALL APPLY TO THE HEALTH CARE PROVIDER'S QUALIFICATION
16 TO PARTICIPATE IN THE PROGRAM; PROVIDED THAT A HEALTH CARE PROVIDER
17 QUALIFIED UNDER THIS SENTENCE SHALL FOLLOW THE PROCEDURES TO BECOME
18 QUALIFIED UNDER THE PROGRAM BY THE END OF THE IMPLEMENTATION PERIOD.

19 (B) THE COMMISSIONER SHALL ESTABLISH AND MAINTAIN PROCEDURES AND STAN-
20 DARDS FOR RECOGNIZING HEALTH CARE PROVIDERS LOCATED OUT OF THE STATE FOR
21 PURPOSES OF PROVIDING COVERAGE UNDER THE PROGRAM FOR OUT-OF-STATE HEALTH
22 CARE SERVICES.

23 4. PAYMENT FOR HEALTH CARE SERVICES. (A) THE COMMISSIONER MAY ESTAB-
24 LISH BY REGULATION PAYMENT METHODOLOGIES FOR HEALTH CARE SERVICES AND
25 CARE COORDINATION PROVIDED TO MEMBERS UNDER THE PROGRAM BY PARTICIPATING
26 PROVIDERS, CARE COORDINATORS, AND HEALTH CARE ORGANIZATIONS. THERE MAY
27 BE A VARIETY OF DIFFERENT PAYMENT METHODOLOGIES, INCLUDING THOSE ESTAB-
28 LISHED ON A DEMONSTRATION BASIS. ALL PAYMENT RATES UNDER THE PROGRAM
29 SHALL BE REASONABLE AND REASONABLY RELATED TO THE COST OF EFFICIENTLY
30 PROVIDING THE HEALTH CARE SERVICE AND ASSURING AN ADEQUATE AND ACCESSI-
31 BLE SUPPLY OF HEALTH CARE SERVICE. UNTIL AND UNLESS ANOTHER PAYMENT
32 METHODOLOGY IS ESTABLISHED, HEALTH CARE SERVICES PROVIDED TO MEMBERS
33 UNDER THE PROGRAM SHALL BE PAID FOR ON A FEE-FOR-SERVICE BASIS, EXCEPT
34 FOR CARE COORDINATION.

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

39 (C) NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, PAYMENT FOR
40 DRUGS PROVIDED BY PHARMACIES UNDER THE PROGRAM SHALL BE MADE PURSUANT TO
41 ARTICLE TWO-A OF THIS CHAPTER. HOWEVER, THE PROGRAM SHALL PROVIDE FOR
42 PAYMENT FOR PRESCRIPTION DRUGS UNDER SECTION 340B OF THE FEDERAL PUBLIC
43 SERVICE ACT WHERE APPLICABLE. PAYMENT FOR PRESCRIPTION DRUGS PROVIDED BY
44 HEALTH CARE PROVIDERS OTHER THAN PHARMACIES SHALL BE PURSUANT TO OTHER
45 PROVISIONS OF THIS ARTICLE.

46 (D) PAYMENT FOR HEALTH CARE SERVICES ESTABLISHED UNDER THIS ARTICLE
47 SHALL BE CONSIDERED PAYMENT IN FULL. A PARTICIPATING PROVIDER SHALL NOT
48 CHARGE ANY RATE IN EXCESS OF THE PAYMENT ESTABLISHED UNDER THIS ARTICLE
49 FOR ANY HEALTH CARE SERVICE UNDER THE PROGRAM PROVIDED TO A MEMBER AND
50 SHALL NOT SOLICIT OR ACCEPT PAYMENT FROM ANY MEMBER OR THIRD PARTY FOR
51 ANY SUCH SERVICE EXCEPT AS PROVIDED UNDER SECTION FIFTY-ONE HUNDRED NINE
52 OF THIS ARTICLE. HOWEVER, THIS PARAGRAPH SHALL NOT PRECLUDE THE PROGRAM
53 FROM ACTING AS A PRIMARY OR SECONDARY PAYER IN CONJUNCTION WITH ANOTHER
54 THIRD-PARTY PAYER WHERE PERMITTED UNDER SECTION FIFTY-ONE HUNDRED NINE
55 OF 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.

(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-ELIGIBLE MEMBERS, SHALL NOT BE CONSIDERED A FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM OR GOVERNMENTAL AGENCY BUT SHALL BE DEEMED TO BE A SPECIFIED THIRD-PARTY PAYOR UNDER ARTICLE TWENTY-EIGHT 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 GOVERNMENTAL 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

1 WITH NATIONAL AND LOCAL ORGANIZATIONS WORKING IN THE FIELD OF HEALTH
2 CARE ORGANIZATIONS, INCLUDING HEALTH CARE PRACTITIONERS, HOSPITALS,
3 CLINICS, AND CONSUMERS AND THEIR REPRESENTATIVES. WHEN DEVELOPING AND
4 IMPLEMENTING STANDARDS OF APPROVAL OF HEALTH CARE ORGANIZATIONS, THE
5 COMMISSIONER SHALL CONSULT WITH THE COMMISSIONER OF MENTAL HEALTH AND
6 THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES.

7 (B) TO MAINTAIN APPROVAL UNDER THE PROGRAM, A HEALTH CARE ORGANIZATION
8 MUST: (I) RENEW ITS STATUS AT A FREQUENCY DETERMINED BY THE COMMISSION-
9 ER; AND (II) PROVIDE DATA TO THE DEPARTMENT AS REQUIRED BY THE COMMIS-
10 SIONER TO ENABLE THE COMMISSIONER TO EVALUATE THE HEALTH CARE ORGANIZA-
11 TION IN RELATION TO QUALITY OF HEALTH CARE SERVICES, HEALTH CARE
12 OUTCOMES, AND COST.

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

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

20 S 5107. PROGRAM STANDARDS. 1. THE COMMISSIONER SHALL ESTABLISH
21 REQUIREMENTS AND STANDARDS FOR THE PROGRAM AND FOR HEALTH CARE ORGANIZA-
22 TIONS, CARE COORDINATORS, AND HEALTH CARE PROVIDERS, CONSISTENT WITH
23 THIS ARTICLE, INCLUDING REQUIREMENTS AND STANDARDS FOR, AS APPLICABLE:

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

25 (B) RELATIONS BETWEEN HEALTH CARE ORGANIZATIONS OR HEALTH CARE PROVID-
26 ERS AND MEMBERS; AND

27 (C) RELATIONS BETWEEN HEALTH CARE ORGANIZATIONS AND HEALTH CARE
28 PROVIDERS, INCLUDING (I) CREDENTIALING AND PARTICIPATION IN THE HEALTH
29 CARE ORGANIZATION; AND (II) TERMS, METHODS AND RATES OF PAYMENT.

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

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

36 (B) PRIMARY AND PREVENTIVE CARE, CARE COORDINATION, EFFICIENT AND
37 EFFECTIVE HEALTH CARE SERVICES, QUALITY ASSURANCE, COORDINATION AND
38 INTEGRATION OF HEALTH CARE SERVICES, INCLUDING USE OF APPROPRIATE TECH-
39 NOLOGY, AND PROMOTION OF PUBLIC, ENVIRONMENTAL AND OCCUPATIONAL HEALTH;

40 (C) ELIMINATION OF HEALTH CARE DISPARITIES;

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

47 (E) ACCESSIBILITY OF CARE COORDINATION, HEALTH CARE ORGANIZATION
48 SERVICES AND HEALTH CARE SERVICES, INCLUDING ACCESSIBILITY FOR PEOPLE
49 WITH DISABILITIES AND PEOPLE WITH LIMITED ABILITY TO SPEAK OR UNDERSTAND
50 ENGLISH, AND THE PROVIDING OF CARE COORDINATION, HEALTH CARE ORGANIZA-
51 TION SERVICES AND HEALTH CARE SERVICES IN A CULTURALLY COMPETENT MANNER.

52 3. ANY PARTICIPATING PROVIDER OR CARE COORDINATOR THAT IS ORGANIZED AS
53 A FOR-PROFIT ENTITY SHALL BE REQUIRED TO MEET THE SAME REQUIREMENTS AND
54 STANDARDS AS ENTITIES ORGANIZED AS NOT-FOR-PROFIT ENTITIES, AND PAYMENTS
55 UNDER THE PROGRAM PAID TO SUCH ENTITIES SHALL NOT BE CALCULATED TO
56 ACCOMMODATE THE GENERATION OF PROFIT OR REVENUE FOR DIVIDENDS OR OTHER

1 RETURN ON INVESTMENT OR THE PAYMENT OF TAXES THAT WOULD NOT BE PAID BY A
2 NOT-FOR-PROFIT ENTITY.

3 4. EVERY PARTICIPATING PROVIDER SHALL FURNISH TO THE PROGRAM SUCH
4 INFORMATION TO, AND PERMIT EXAMINATION OF ITS RECORDS BY, THE PROGRAM,
5 AS MAY BE REASONABLY REQUIRED FOR PURPOSES OF REVIEWING ACCESSIBILITY
6 AND UTILIZATION OF HEALTH CARE SERVICES, QUALITY ASSURANCE, AND COST
7 CONTAINMENT, THE MAKING OF PAYMENTS, AND STATISTICAL OR OTHER STUDIES OF
8 THE OPERATION OF THE PROGRAM OR FOR PROTECTION AND PROMOTION OF PUBLIC,
9 ENVIRONMENTAL AND OCCUPATIONAL HEALTH.

10 5. IN DEVELOPING REQUIREMENTS AND STANDARDS AND MAKING OTHER POLICY
11 DETERMINATIONS UNDER THIS ARTICLE, THE COMMISSIONER SHALL CONSULT WITH
12 REPRESENTATIVES OF MEMBERS, HEALTH CARE PROVIDERS, CARE COORDINATORS,
13 HEALTH CARE ORGANIZATIONS AND OTHER INTERESTED PARTIES.

14 6. THE PROGRAM SHALL MAINTAIN THE CONFIDENTIALITY OF ALL DATA AND
15 OTHER INFORMATION COLLECTED UNDER THE PROGRAM WHEN SUCH DATA WOULD BE
16 NORMALLY CONSIDERED CONFIDENTIAL DATA BETWEEN A PATIENT AND HEALTH CARE
17 PROVIDER. AGGREGATE DATA OF THE PROGRAM WHICH IS DERIVED FROM CONFIDEN-
18 TIAL DATA BUT DOES NOT VIOLATE PATIENT CONFIDENTIALITY SHALL BE PUBLIC
19 INFORMATION.

20 S 5108. REGULATIONS. THE COMMISSIONER MAY APPROVE REGULATIONS AND
21 AMENDMENTS THERETO, UNDER SUBDIVISION ONE OF SECTION FIFTY-ONE HUNDRED
22 TWO OF THIS ARTICLE. THE COMMISSIONER MAY MAKE REGULATIONS OR AMENDMENTS
23 THERETO TO EFFECTUATE THE PROVISIONS AND PURPOSES OF THIS ARTICLE ON AN
24 EMERGENCY BASIS UNDER SECTION TWO HUNDRED TWO OF THE STATE ADMINISTRA-
25 TIVE PROCEDURE ACT, PROVIDED THAT SUCH REGULATIONS OR AMENDMENTS SHALL
26 NOT BECOME PERMANENT UNLESS ADOPTED UNDER SUBDIVISION ONE OF SECTION
27 FIFTY-ONE HUNDRED TWO OF THIS ARTICLE.

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

32 2. (A) THE COMMISSIONER SHALL APPLY TO THE SECRETARY OF HEALTH AND
33 HUMAN SERVICES OR OTHER APPROPRIATE FEDERAL OFFICIAL FOR ALL WAIVERS OF
34 REQUIREMENTS, AND MAKE OTHER ARRANGEMENTS, UNDER MEDICARE, ANY FEDERAL-
35 LY-MATCHED PUBLIC HEALTH PROGRAM, THE AFFORDABLE CARE ACT, AND ANY OTHER
36 FEDERAL PROGRAMS THAT PROVIDE FEDERAL FUNDS FOR PAYMENT FOR HEALTH CARE
37 SERVICES, THAT ARE NECESSARY TO ENABLE ALL NEW YORK HEALTH MEMBERS TO
38 RECEIVE ALL BENEFITS UNDER THE PROGRAM THROUGH THE PROGRAM TO ENABLE THE
39 STATE TO IMPLEMENT THIS ARTICLE AND TO RECEIVE AND DEPOSIT ALL FEDERAL
40 PAYMENTS UNDER THOSE PROGRAMS (INCLUDING FUNDS THAT MAY BE PROVIDED IN
41 LIEU OF PREMIUM TAX CREDITS, COST-SHARING SUBSIDIES, AND SMALL BUSINESS
42 TAX CREDITS) IN THE STATE TREASURY TO THE CREDIT OF THE NEW YORK HEALTH
43 TRUST FUND CREATED UNDER SECTION EIGHTY-NINE-I OF THE STATE FINANCE LAW
44 AND TO USE THOSE FUNDS FOR THE NEW YORK HEALTH PROGRAM AND OTHER
45 PROVISIONS UNDER THIS ARTICLE. TO THE EXTENT POSSIBLE, THE COMMISSIONER
46 SHALL NEGOTIATE ARRANGEMENTS WITH THE FEDERAL GOVERNMENT IN WHICH BULK
47 OR LUMP-SUM FEDERAL PAYMENTS ARE PAID TO NEW YORK HEALTH IN PLACE OF
48 FEDERAL SPENDING OR TAX BENEFITS FOR FEDERALLY-MATCHED HEALTH PROGRAMS
49 OR FEDERAL HEALTH PROGRAMS.

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

53 3. (A) IF ACTIONS TAKEN UNDER SUBDIVISION TWO OF THIS SECTION DO NOT
54 ACCOMPLISH ALL RESULTS INTENDED UNDER THAT SUBDIVISION, THEN THIS SUBDI-
55 VISION SHALL APPLY AND SHALL AUTHORIZE ADDITIONAL ACTIONS TO EFFECTIVELY

1 IMPLEMENT NEW YORK HEALTH TO THE MAXIMUM EXTENT POSSIBLE AS A
2 SINGLE-PAYER PROGRAM CONSISTENT WITH THIS ARTICLE.

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

7 (C) THE COMMISSIONER MAY WAIVE OR MODIFY THE APPLICABILITY OF
8 PROVISIONS OF THIS SECTION RELATING TO ANY FEDERALLY-MATCHED PUBLIC
9 HEALTH PROGRAM OR MEDICARE AS NECESSARY TO IMPLEMENT ANY WAIVER OR
10 ARRANGEMENT UNDER THIS SECTION OR TO MAXIMIZE THE BENEFIT TO THE NEW
11 YORK HEALTH PROGRAM UNDER THIS SECTION, PROVIDED THAT THE COMMISSIONER,
12 IN CONSULTATION WITH THE DIRECTOR OF THE BUDGET, SHALL DETERMINE THAT
13 SUCH WAIVER OR MODIFICATION IS IN THE BEST INTERESTS OF THE MEMBERS
14 AFFECTED BY THE ACTION AND THE STATE.

15 (D) THE COMMISSIONER MAY APPLY FOR COVERAGE UNDER ANY
16 FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM ON BEHALF OF ANY MEMBER AND
17 ENROLL THE MEMBER IN THE FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM OR
18 MEDICARE IF THE MEMBER IS ELIGIBLE FOR IT. ENROLLMENT IN A
19 FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM OR MEDICARE SHALL NOT CAUSE ANY
20 MEMBER TO LOSE ANY HEALTH CARE SERVICE PROVIDED BY THE PROGRAM OR DIMIN-
21 ISH ANY RIGHT THE MEMBER WOULD OTHERWISE HAVE.

22 (E) THE COMMISSIONER SHALL BY REGULATION INCREASE THE INCOME ELIGIBIL-
23 ITY LEVEL, INCREASE OR ELIMINATE THE RESOURCE TEST FOR ELIGIBILITY,
24 SIMPLIFY ANY PROCEDURAL OR DOCUMENTATION REQUIREMENT FOR ENROLLMENT, AND
25 INCREASE THE BENEFITS FOR ANY FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM,
26 NOTWITHSTANDING ANY LAW OR REGULATION TO THE CONTRARY. THE COMMISSIONER
27 MAY ACT UNDER THIS PARAGRAPH UPON A FINDING, APPROVED BY THE DIRECTOR OF
28 THE BUDGET, THAT THE ACTION (I) WILL HELP TO INCREASE THE NUMBER OF
29 MEMBERS WHO ARE ELIGIBLE FOR AND ENROLLED IN FEDERALLY-MATCHED PUBLIC
30 HEALTH PROGRAMS; (II) WILL NOT DIMINISH ANY INDIVIDUAL'S ACCESS TO ANY
31 HEALTH CARE SERVICE OR RIGHT THE INDIVIDUAL WOULD OTHERWISE HAVE; (III)
32 IS IN THE INTEREST OF THE PROGRAM; AND (IV) DOES NOT REQUIRE OR HAS
33 RECEIVED ANY NECESSARY FEDERAL WAIVERS OR APPROVALS TO ENSURE FEDERAL
34 FINANCIAL PARTICIPATION. ACTIONS UNDER THIS PARAGRAPH SHALL NOT APPLY TO
35 ELIGIBILITY FOR PAYMENT FOR LONG TERM CARE.

36 (F) TO ENABLE THE COMMISSIONER TO APPLY FOR COVERAGE UNDER ANY FEDER-
37 ALLY-MATCHED PUBLIC HEALTH PROGRAM OR MEDICARE ON BEHALF OF ANY MEMBER
38 AND ENROLL THE MEMBER IN THE FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM OR
39 MEDICARE IF THE MEMBER IS ELIGIBLE FOR IT, THE COMMISSIONER MAY REQUIRE
40 THAT EVERY MEMBER OR APPLICANT TO BE A MEMBER SHALL PROVIDE INFORMATION
41 TO ENABLE THE COMMISSIONER TO DETERMINE WHETHER THE APPLICANT IS ELIGI-
42 BLE FOR A FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM AND FOR MEDICARE (AND
43 ANY PROGRAM OR BENEFIT UNDER MEDICARE). THE PROGRAM SHALL MAKE A REASON-
44 ABLE EFFORT TO NOTIFY MEMBERS OF THEIR OBLIGATIONS UNDER THIS PARAGRAPH.
45 AFTER A REASONABLE EFFORT HAS BEEN MADE TO CONTACT THE MEMBER, THE
46 MEMBER SHALL BE NOTIFIED IN WRITING THAT HE OR SHE HAS SIXTY DAYS TO
47 PROVIDE SUCH REQUIRED INFORMATION. IF SUCH INFORMATION IS NOT PROVIDED
48 WITHIN THE SIXTY DAY PERIOD, THE MEMBER'S COVERAGE UNDER THE PROGRAM MAY
49 BE TERMINATED.

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

53 (H) THE PROGRAM SHALL PROVIDE PREMIUM ASSISTANCE FOR ALL MEMBERS
54 ENROLLING IN A MEDICARE PART D DRUG COVERAGE UNDER SECTION 1860D OF
55 TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT LIMITED TO THE LOW-INCOME
56 BENCHMARK PREMIUM AMOUNT ESTABLISHED BY THE FEDERAL CENTERS FOR MEDICARE

1 AND MEDICAID SERVICES AND ANY OTHER AMOUNT WHICH SUCH AGENCY ESTABLISHES
2 UNDER ITS DE MINIMIS PREMIUM POLICY, EXCEPT THAT SUCH PAYMENTS MADE ON
3 BEHALF OF MEMBERS ENROLLED IN A MEDICARE ADVANTAGE PLAN MAY EXCEED THE
4 LOW-INCOME BENCHMARK PREMIUM AMOUNT IF DETERMINED TO BE COST EFFECTIVE
5 TO THE PROGRAM.

6 (I) IF THE COMMISSIONER HAS REASONABLE GROUNDS TO BELIEVE THAT A
7 MEMBER COULD BE ELIGIBLE FOR AN INCOME-RELATED SUBSIDY UNDER SECTION
8 1860D-14 OF TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT, THE MEMBER
9 SHALL PROVIDE, AND AUTHORIZE THE PROGRAM TO OBTAIN, ANY INFORMATION OR
10 DOCUMENTATION REQUIRED TO ESTABLISH THE MEMBER'S ELIGIBILITY FOR SUCH
11 SUBSIDY, PROVIDED THAT THE COMMISSIONER SHALL ATTEMPT TO OBTAIN AS MUCH
12 OF THE INFORMATION AND DOCUMENTATION AS POSSIBLE FROM RECORDS THAT ARE
13 AVAILABLE TO HIM OR HER.

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

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

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

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

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

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

37 3. THE COMMISSIONER SHALL PROVIDE FUNDS FROM THE NEW YORK HEALTH TRUST
38 FUND OR OTHERWISE APPROPRIATED FOR THIS PURPOSE TO THE COMMISSIONER OF
39 LABOR FOR A PROGRAM FOR RETRAINING AND ASSISTING JOB TRANSITION FOR
40 INDIVIDUALS EMPLOYED OR PREVIOUSLY EMPLOYED IN THE FIELD OF HEALTH
41 INSURANCE AND OTHER THIRD-PARTY PAYMENT FOR HEALTH CARE OR PROVIDING
42 SERVICES TO HEALTH CARE PROVIDERS TO DEAL WITH THIRD-PARTY PAYERS FOR
43 HEALTH CARE, WHOSE JOBS MAY BE OR HAVE BEEN ENDED AS A RESULT OF THE
44 IMPLEMENTATION OF THE NEW YORK HEALTH PROGRAM, CONSISTENT WITH OTHERWISE
45 APPLICABLE LAW.

46 4. THE COMMISSIONER SHALL, DIRECTLY AND THROUGH GRANTS TO NOT-FOR-PRO-
47 FIT ENTITIES, CONDUCT PROGRAMS USING DATA COLLECTED THROUGH THE NEW YORK
48 HEALTH PROGRAM, TO PROMOTE AND PROTECT PUBLIC, ENVIRONMENTAL AND OCCUPA-
49 TIONAL HEALTH, INCLUDING COOPERATION WITH OTHER DATA COLLECTION AND
50 RESEARCH PROGRAMS OF THE DEPARTMENT, CONSISTENT WITH THIS ARTICLE AND
51 OTHERWISE APPLICABLE LAW.

52 S 4. Financing of New York Health. 1. The governor shall submit to the
53 legislature a revenue plan and legislative bills to implement the plan
54 (referred to collectively in this section as the "revenue proposal") to
55 provide the revenue necessary to finance the New York Health program, as
56 created by article 51 of the public health law (referred to in this

1 section as the "program"), taking into consideration anticipated federal
2 revenue available for the program. The revenue proposal shall be submit-
3 ted to the legislature as part of the executive budget under article VII
4 of the state constitution, for the fiscal year commencing on the first
5 day of April in the calendar year after this act shall become a law. In
6 developing the revenue proposal, the governor shall consult with appro-
7 priate officials of the executive branch; the temporary president of the
8 senate; the speaker of the assembly; the chairs of the fiscal and health
9 committees of the senate and assembly; and representatives of business,
10 labor, consumers and local government.

11 2. (a) Basic structure. The basic structure of the revenue proposal
12 shall be as follows: Revenue for the program shall come from two assess-
13 ments (referred to collectively in this section as the "assessments").
14 First, there shall be a progressively graduated assessment on all
15 payroll and self-employed income (referred to in this section as the
16 "payroll assessment"), paid by employers, employees and self-employed,
17 similar to the Medicare tax. Higher brackets of income subject to this
18 assessment shall be assessed at a higher marginal rate than lower brack-
19 ets. Second, there shall be a progressively graduated assessment on
20 taxable income (such as interest, dividends, and capital gains) not
21 subject to the payroll assessment (referred to in this section as the
22 "non-payroll assessment"). The assessments will be set at levels antic-
23 ipated to produce sufficient revenue to finance the program and other
24 provisions of article 51 of the public health law, to be scaled up as
25 enrollment grows, taking into consideration anticipated federal revenue
26 available for the program. Provision shall be made for state residents
27 (who are eligible for the program) who are employed out-of-state, and
28 non-residents (who are not eligible for the program) who are employed in
29 the state.

30 (b) Payroll assessment. The income to be subject to the payroll
31 assessment shall be all income subject to the Medicare tax. The assess-
32 ment shall be set at a particular percentage of that income, which shall
33 be progressively graduated, so the percentage is higher on higher brack-
34 ets of income. For employed individuals, the employer shall pay eighty
35 percent of the assessment and the employee shall pay twenty percent of
36 the assessment, except that an employer may agree to pay all or part of
37 the employee's share. A self-employed individual shall pay the full
38 assessment.

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

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

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

1 (ii) Out-of-state residents employed in the state. (A) The payroll
2 assessment shall apply to any out-of-state resident who is employed or
3 self-employed in the state. (B) In the case of an out-of-state resident
4 who is employed or self-employed in the state, such individual and indi-
5 vidual's employer shall be able to take a credit against the payroll
6 assessments they would otherwise pay, as to the individual for amounts
7 they spend on health benefits for the individual that would otherwise be
8 covered by the program if the individual were a member of the program.
9 For employers, the credit shall be available regardless of the form of
10 the health benefit (e.g., health insurance, a self-insured plan, direct
11 services, or reimbursement for services), to make sure that the revenue
12 proposal does not relate to employment benefits in violation of the
13 federal ERISA. For non-employment-based spending by individuals, the
14 credit shall be available for and limited to spending for health cover-
15 age (not out-of-pocket health spending). The credit shall be available
16 without regard to how little is spent or how sparse the benefit. The
17 credit may only be taken against the payroll assessments. Any excess
18 amount may not be applied to other tax liability. For employment-based
19 health benefits, the credit shall be distributed between the employer
20 and employee in the same proportion as the spending by each for the
21 benefit. The employer and employee may each apply their respective
22 portion of the credit to their respective portion of the assessment. If
23 any provision of this clause or any application of it shall be ruled to
24 violate federal ERISA, the provision or the application of it shall be
25 null and void and the ruling shall not affect any other provision or
26 application of this section or the act that enacted it.

27 3. The revenue proposal shall include a plan and legislative
28 provisions for ending the requirement for local social services
29 districts to pay part of the cost of Medicaid and replacing those
30 payments with revenue from the assessments under the revenue proposal.

31 4. To the extent that the revenue proposal differs from the terms of
32 subdivision two of this section, the revenue proposal shall state how it
33 differs from those terms and reasons for and the effects of the differ-
34 ences.

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

37 S 5. Article 49 of the public health law is amended by adding a new
38 title 3 to read as follows:

39 TITLE III

40 COLLECTIVE NEGOTIATIONS BY HEALTH CARE PROVIDERS WITH 41 NEW YORK HEALTH

42 SECTION 4920. DEFINITIONS.

43 4921. COLLECTIVE NEGOTIATION AUTHORIZED.

44 4922. COLLECTIVE NEGOTIATION REQUIREMENTS.

45 4923. REQUIREMENTS FOR HEALTH CARE PROVIDERS' REPRESENTATIVE.

46 4924. CERTAIN COLLECTIVE ACTION PROHIBITED.

47 4925. FEES.

48 4926. CONFIDENTIALITY.

49 4927. SEVERABILITY AND CONSTRUCTION.

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

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

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

55 3. "HEALTH CARE PROVIDERS' REPRESENTATIVE" MEANS A THIRD PARTY THAT IS
56 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, REGISTERED OR AUTHORIZED TO PRACTICE A HEALTH CARE PROFESSION PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW AND WHO PRACTICES THAT PROFESSION 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 WITH NEW YORK HEALTH ON ANY MATTER RELATING TO NEW YORK HEALTH, INCLUDING BUT NOT LIMITED TO RATES OF PAYMENT AND PAYMENT METHODOLOGIES.

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.

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;

(C) A HEALTH CARE PROVIDERS' REPRESENTATIVE IS THE ONLY PARTY AUTHORIZED TO NEGOTIATE WITH NEW YORK HEALTH 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, NEW YORK HEALTH IS ENTITLED TO OFFER AND PROVIDE DIFFERENT TERMS AND CONDITIONS TO INDIVIDUAL COMPETING HEALTH CARE PROVIDERS.

2. NOTHING IN THIS TITLE SHALL 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.

3. NOTHING IN THIS TITLE SHALL AFFECT OR LIMIT COLLECTIVE ACTION OR COLLECTIVE BARGAINING ON THE PART OF ANY HEALTH CARE PROVIDER WITH HIS OR HER EMPLOYER OR ANY OTHER LAWFUL COLLECTIVE ACTION OR COLLECTIVE BARGAINING.

S 4923. REQUIREMENTS FOR HEALTH CARE PROVIDERS' REPRESENTATIVE. BEFORE ENGAGING IN COLLECTIVE NEGOTIATIONS WITH NEW YORK HEALTH 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.

S 4924. CERTAIN COLLECTIVE ACTION PROHIBITED. 1. THIS TITLE IS NOT INTENDED TO AUTHORIZE COMPETING HEALTH CARE PROVIDERS TO ACT IN CONCERT IN RESPONSE TO A HEALTH CARE PROVIDERS' REPRESENTATIVE'S DISCUSSIONS OR NEGOTIATIONS WITH NEW YORK HEALTH EXCEPT AS AUTHORIZED BY OTHER LAW.

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 4925. FEES. EACH PERSON WHO ACTS AS THE REPRESENTATIVE OF 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.

S 4926. CONFIDENTIALITY. ALL REPORTS AND OTHER INFORMATION REQUIRED TO BE REPORTED TO THE DEPARTMENT UNDER 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 4927. SEVERABILITY AND CONSTRUCTION. IF ANY PROVISION OR APPLICATION OF THIS TITLE SHALL BE HELD TO BE INVALID, OR TO VIOLATE OR BE INCONSISTENT WITH ANY APPLICABLE FEDERAL LAW OR REGULATION, THAT SHALL NOT AFFECT OTHER PROVISIONS OR APPLICATIONS OF THIS TITLE WHICH CAN BE GIVEN EFFECT WITHOUT THAT PROVISION OR APPLICATION; AND TO THAT END, THE PROVISIONS AND APPLICATIONS OF THIS TITLE ARE SEVERABLE. THE PROVISIONS OF THIS TITLE SHALL BE LIBERALLY CONSTRUED TO GIVE EFFECT TO THE PURPOSES THEREOF.

S 6. Subdivision 11 of section 270 of the public health law, as amended by section 2-a of part C of chapter 58 of the laws of 2008, is amended to read as follows:

11. "State public health plan" means the medical assistance program established by title eleven of article five of the social services law (referred to in this article as "Medicaid"), the elderly pharmaceutical insurance coverage program established by title three of article two of the elder law (referred to in this article as "EPIC"), and the [family health plus program established by section three hundred sixty-nine-ee of the social services law to the extent that section provides that the program shall be subject to this article] NEW YORK HEALTH PROGRAM ESTABLISHED BY ARTICLE FIFTY-ONE OF THIS CHAPTER.

S 7. The state finance law is amended by adding a new section 89-i to read as follows:

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

2. THE FUND SHALL CONSIST OF:

(A) ALL MONIES OBTAINED FROM ASSESSMENTS PURSUANT TO LEGISLATION ENACTED AS PROPOSED UNDER SECTION THREE OF THE NEW YORK HEALTH ACT;

(B) FEDERAL PAYMENTS RECEIVED AS A RESULT OF ANY WAIVER OF REQUIREMENTS GRANTED OR OTHER ARRANGEMENTS AGREED TO BY THE UNITED STATES

1 SECRETARY OF HEALTH AND HUMAN SERVICES OR OTHER APPROPRIATE FEDERAL
2 OFFICIALS FOR HEALTH CARE PROGRAMS ESTABLISHED UNDER MEDICARE, ANY
3 FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM, OR THE AFFORDABLE CARE ACT;

4 (C) THE AMOUNTS PAID BY THE DEPARTMENT OF HEALTH THAT ARE EQUIVALENT
5 TO THOSE AMOUNTS THAT ARE PAID ON BEHALF OF RESIDENTS OF THIS STATE
6 UNDER MEDICARE, ANY FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM, OR THE
7 AFFORDABLE CARE ACT FOR HEALTH BENEFITS WHICH ARE EQUIVALENT TO HEALTH
8 BENEFITS COVERED UNDER NEW YORK HEALTH;

9 (D) FEDERAL AND STATE FUNDS FOR PURPOSES OF THE PROVISION OF SERVICES
10 AUTHORIZED UNDER TITLE XX OF THE FEDERAL SOCIAL SECURITY ACT THAT WOULD
11 OTHERWISE BE COVERED UNDER ARTICLE FIFTY-ONE OF THE PUBLIC HEALTH LAW;
12 AND

13 (E) STATE MONIES THAT WOULD OTHERWISE BE APPROPRIATED TO ANY GOVERN-
14 MENTAL AGENCY, OFFICE, PROGRAM, INSTRUMENTALITY OR INSTITUTION WHICH
15 PROVIDES HEALTH SERVICES, FOR SERVICES AND BENEFITS COVERED UNDER NEW
16 YORK HEALTH. PAYMENTS TO THE FUND PURSUANT TO THIS PARAGRAPH SHALL BE IN
17 AN AMOUNT EQUAL TO THE MONEY APPROPRIATED FOR SUCH PURPOSES IN THE
18 FISCAL YEAR BEGINNING IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF THE
19 NEW YORK HEALTH ACT.

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

22 S 8. Temporary commission on implementation. 1. There is hereby estab-
23 lished a temporary commission on implementation of the New York Health
24 program, hereinafter to be known as the commission, consisting of
25 fifteen members: five members, including the chair, shall be appointed
26 by the governor; four members shall be appointed by the temporary presi-
27 dent of the senate, one member shall be appointed by the senate minority
28 leader; four members shall be appointed by the speaker of the assembly,
29 and one member shall be appointed by the assembly minority leader. The
30 commissioner of health, the superintendent of financial services, and
31 the commissioner of taxation and finance, or their designees shall serve
32 as non-voting ex-officio members of the commission.

33 2. Members of the commission shall receive such assistance as may be
34 necessary from other state agencies and entities, and shall receive
35 necessary expenses incurred in the performance of their duties. The
36 commission may employ staff as needed, prescribe their duties, and fix
37 their compensation within amounts appropriated for the commission.

38 3. The commission shall examine the laws and regulations of the state
39 and make such recommendations as are necessary to conform the laws and
40 regulations of the state and article 51 of the public health law estab-
41 lishing the New York Health program and other provisions of law relating
42 to the New York Health program, and to improve and implement the
43 program. The commission shall report its recommendations to the governor
44 and the legislature.

45 S 9. Severability. If any provision or application of this act shall
46 be held to be invalid, or to violate or be inconsistent with any appli-
47 cable federal law or regulation, that shall not affect other provisions
48 or applications of this act which can be given effect without that
49 provision or application; and to that end, the provisions and applica-
50 tions of this act are severable.

51 S 10. This act shall take effect immediately.