

STATE OF NEW YORK

5248

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IN ASSEMBLY

February 8, 2019

Introduced by M. of A. GOTTFRIED, ABINANTI, BARRETT, BARRON, BENEDETTO, BICHOTTE, BLAKE, BRONSON, BURKE, CAHILL, CARROLL, COLTON, COOK, CRESPO, CRUZ, CYMBROWITZ, DE LA ROSA, DICKENS, DILAN, DINOWITZ, D'URSO, ENGLEBRIGHT, EPSTEIN, FERNANDEZ, FRONTUS, GANTT, HUNTER, HYNDMAN, JAFFEE, JEAN-PIERRE, JOYNER, KIM, LAVINE, LIFTON, LUPARDO, M. G. MILLER, MOSLEY, NIOU, ORTIZ, PAULIN, PEOPLES-STOKES, PERRY, PHEFFER AMATO, PICHARDO, RAMOS, REYES, RICHARDSON, RIVERA, RODRIGUEZ, L. ROSENTHAL, SEAWRIGHT, SIMON, SIMOTAS, SOLAGES, STECK, STIRPE, TAYLOR, THIELE, TITUS, VANEL, WALKER, WALLACE, WEINSTEIN, WEPRIN, WILLIAMS, WRIGHT -- Multi-Sponsored by -- M. of A. ABBATE, ARROYO, AUBRY, DAVILA, DenDEKKER, FAHY, GALEF, GLICK, GUNTHER, LENTOL, MAGNARELLI, O'DONNELL, PRETLOW, QUART, ROZIC -- read once and referred 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 § 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, §3.) 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. Millions of New Yorkers do not get the health care
13 they need or face financial obstacles and hardships to get it. That is
14 not acceptable. There is no plan other than the New York health act

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

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1 that will enable New York state to meet that need. New Yorkers - as
2 individuals, employers, and taxpayers - have experienced a rise in the
3 cost of health care and coverage in recent years, including rising
4 premiums, deductibles and co-pays, restricted provider networks and high
5 out-of-network charges. Many New Yorkers go without health care because
6 they cannot afford it or suffer financial hardship to get it. Busi-
7 nesses have also experienced increases in the costs of health care bene-
8 fits for their employees, and many employers are shifting a larger share
9 of the cost of coverage to their employees or dropping coverage entire-
10 ly. Including long-term services and supports (LTSS) in New York Health
11 is a major step forward for older adults, people with disabilities, and
12 their families. Older adults and people with disabilities often cannot
13 receive the services necessary to stay in the community or other LTSS.
14 Even when older adults and people with disabilities receive LTSS, espe-
15 cially services in the community, it is often at the cost of unreason-
16 able demands on unpaid family caregivers, depleting their own or family
17 resources, or impoverishing themselves to qualify for public coverage.
18 Health care providers are also affected by inadequate health coverage in
19 New York state. A large portion of hospitals, health centers and other
20 providers now experience substantial losses due to the provision of care
21 that is uncompensated. Individuals often find that they are deprived of
22 affordable care and choice because of decisions by health plans guided
23 by the plan's economic interests rather than the individual's health
24 care needs. To address the fiscal crisis facing the health care system
25 and the state and to assure New Yorkers can exercise their right to
26 health care, affordable and comprehensive health coverage must be
27 provided. Pursuant to the state constitution's charge to the legislature
28 to provide for the health of New Yorkers, this legislation is an enact-
29 ment of state concern for the purpose of establishing a comprehensive
30 universal guaranteed health care coverage program and a health care cost
31 control system for the benefit of all residents of the state of New
32 York.

33 2. (a) It is the intent of the Legislature to create the New York
34 Health program to provide a universal single payer health plan for every
35 New Yorker, funded by broad-based revenue based on ability to pay. The
36 legislature intends that federal waivers and approvals be sought where
37 they will improve the administration of the New York Health program, but
38 the legislature intends that the program be implemented even in the
39 absence of such waivers or approvals. The state shall work to obtain
40 waivers and other approvals relating to Medicaid, Child Health Plus,
41 Medicare, the Affordable Care Act, and any other appropriate federal
42 programs, under which federal funds and other subsidies that would
43 otherwise be paid to New York State, New Yorkers, and health care
44 providers for health coverage that will be equaled or exceeded by New
45 York Health will be paid by the federal government to New York State and
46 deposited in the New York Health trust fund, or paid to health care
47 providers and individuals in combination with New York Health trust fund
48 payments, and for other program modifications (including elimination of
49 cost sharing and insurance premiums). Under such waivers and approvals,
50 health coverage under those programs will, to the maximum extent possi-
51 ble, be replaced and merged into New York Health, which will operate as
52 a true single-payer program.

53 (b) If any necessary waiver or approval is not obtained, the state
54 shall use state plan amendments and seek waivers and approvals to maxi-
55 mize, and make as seamless as possible, the use of federally-matched
56 health programs and federal health programs in New York Health. Thus,

1 even where other programs such as Medicaid or Medicare may contribute to
2 paying for care, it is the goal of this legislation that the coverage
3 will be delivered by New York Health and, as much as possible, the
4 multiple sources of funding will be pooled with other New York Health
5 funds and not be apparent to New York Health members or participating
6 providers.

7 (c) This program will promote movement away from fee-for-service
8 payment, which tends to reward quantity and requires excessive adminis-
9 trative expense, and towards alternate payment methodologies, such as
10 global or capitated payments to providers or health care organizations,
11 that promote quality, efficiency, investment in primary and preventive
12 care, and innovation and integration in the organizing of health care.

13 (d) The program shall promote the use of clinical data to improve the
14 quality of health care and public health, consistent with protection of
15 patient confidentiality. The program shall maximize patient autonomy in
16 choice of health care providers and health care decision making. Care
17 coordination within the program shall ensure management and coordination
18 among a patient's health care services, consistent with patient autonomy
19 and person-centered service planning, rather than acting as a gatekeeper
20 to needed services.

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

23 4. In order to promote improved quality of, and access to, health care
24 services and promote improved clinical outcomes, it is the policy of the
25 state to encourage cooperative, collaborative and integrative arrange-
26 ments among health care providers who might otherwise be competitors,
27 under the active supervision of the commissioner of health. It is the
28 intent of the state to supplant competition with such arrangements and
29 regulation only to the extent necessary to accomplish the purposes of
30 this act, and to provide state action immunity under the state and
31 federal antitrust laws to health care providers, particularly with
32 respect to their relations with the single-payer New York Health plan
33 created by this act.

34 § 3. Article 50 and sections 5000, 5001, 5002 and 5003 of the public
35 health law are renumbered article 80 and sections 8000, 8001, 8002 and
36 8003, respectively, and a new article 51 is added to read as follows:

37 ARTICLE 51

38 NEW YORK HEALTH

39 Section 5100. Definitions.

40 5101. Program created.

41 5102. Board of trustees.

42 5103. Eligibility and enrollment.

43 5104. Benefits.

44 5105. Health care providers; care coordination; payment method-
45 ologies.

46 5106. Health care organizations.

47 5107. Program standards.

48 5108. Regulations.

49 5109. Provisions relating to federal health programs.

50 5110. Additional provisions.

51 5111. Regional advisory councils.

52 § 5100. Definitions. As used in this article, the following terms
53 shall have the following meanings, unless the context clearly requires
54 otherwise:

1 1. "Board" means the board of trustees of the New York Health program
2 created by section fifty-one hundred two of this article, and "trustee"
3 means a trustee of the board.

4 2. "Care coordination" means, but is not limited to, managing, refer-
5 ring to, locating, coordinating, and monitoring health care services for
6 the member to assure that all medically necessary health care services
7 are made available to and are effectively used by the member in a timely
8 manner, consistent with patient autonomy. Care coordination does not
9 include a requirement for prior authorization for health care services
10 or for referral for a member to receive a health care service.

11 3. "Care coordinator" means an individual or entity approved to
12 provide care coordination under subdivision two of section fifty-one
13 hundred five of this article.

14 4. "Federally-matched public health program" means the medical assist-
15 ance program under title eleven of article five of the social services
16 law, the basic health program under section three hundred sixty-nine-gg
17 of the social services law, and the child health plus program under
18 title one-A of article twenty-five of this chapter.

19 5. "Health care organization" means an entity that is approved by the
20 commissioner under section fifty-one hundred six of this article to
21 provide health care services to members under the program.

22 6. "Health care provider" means any individual or entity legally
23 authorized to provide a health care service under Medicaid or Medicare
24 or this article. "Health care professional" means a health care provider
25 that is an individual licensed, certified, registered or otherwise
26 authorized to practice under title eight of the education law to provide
27 such health care service, acting within his or her lawful scope of prac-
28 tice.

29 7. "Health care service" means any health care service, including care
30 coordination, included as a benefit under the program.

31 8. "Implementation period" means the period under subdivision three of
32 section fifty-one hundred one of this article during which the program
33 will be subject to special eligibility and financing provisions until it
34 is fully implemented under that section.

35 10. "Medicaid" or "medical assistance" means title eleven of article
36 five of the social services law and the program thereunder. "Child
37 health plus" means title one-A of article twenty-five of this chapter
38 and the program thereunder. "Medicare" means title XVIII of the federal
39 social security act and the programs thereunder. "Affordable care act"
40 means the federal patient protection and affordable care act, public law
41 111-148, as amended by the health care and education reconciliation act
42 of 2010, public law 111-152, and as otherwise amended and any regu-
43 lations or guidance issued thereunder. "Basic health program" means
44 section three hundred sixty-nine-gg of the social services law and the
45 program thereunder.

46 11. "Member" means an individual who is enrolled in the program.

47 12. "New York Health", "New York Health program", and "program" mean
48 the New York Health program created by section fifty-one hundred one of
49 this article.

50 13. "New York Health trust fund" means the New York Health trust fund
51 established under section eighty-nine-j of the state finance law.

52 14. "Out-of-state health care service" means a health care service
53 provided to a member while the member is temporarily out of the state
54 and (a) it is medically necessary that the health care service be
55 provided while the member is out of the state, or (b) it is clinically
56 appropriate that the health care service be provided by a particular

1 health care provider located out of the state rather than in the state.
2 However, any health care service provided to a New York Health enrollee
3 by a health care provider qualified under paragraph (a) of subdivision
4 three of section fifty-one hundred five of this article that is located
5 outside the state shall not be considered an out-of-state service and
6 shall be covered as otherwise provided in this article.

7 15. "Participating provider" means any individual or entity that is a
8 health care provider qualified under subdivision three of section
9 fifty-one hundred five of this article that provides health care
10 services to members under the program, or a health care organization.

11 16. "Person" means any individual or natural person, trust, partner-
12 ship, association, unincorporated association, corporation, company,
13 limited liability company, proprietorship, joint venture, firm, joint
14 stock association, department, agency, authority, or other legal entity,
15 whether for-profit, not-for-profit or governmental.

16 17. "Prescription and non-prescription drugs" means prescription drugs
17 as defined in section two hundred seventy of this chapter, and non-pres-
18 cription smoking cessation products or devices.

19 18. "Resident" means an individual whose primary place of abode is in
20 the state, without regard to the individual's immigration status, as
21 determined according to regulations of the commissioner.

22 § 5101. Program created. 1. The New York Health program is hereby
23 created in the department. The commissioner shall establish and imple-
24 ment the program under this article. The program shall provide compre-
25 hensive health coverage to every resident who enrolls in the program.

26 2. The commissioner shall, to the maximum extent possible, organize,
27 administer and market the program and services as a single program under
28 the name "New York Health" or such other name as the commissioner shall
29 determine, regardless of under which law or source the definition of a
30 benefit is found including (on a voluntary basis) retiree health bene-
31 fits. In implementing this article, the commissioner shall avoid jeop-
32 ardizing federal financial participation in these programs and shall
33 take care to promote public understanding and awareness of available
34 benefits and programs.

35 3. The commissioner shall determine when individuals may begin enroll-
36 ing in the program. There shall be an implementation period, which shall
37 begin on the date that individuals may begin enrolling in the program
38 and shall end as determined by the commissioner.

39 4. An insurer authorized to provide coverage pursuant to the insurance
40 law or a health maintenance organization certified under this chapter
41 may, if otherwise authorized, offer benefits that do not cover any
42 service for which coverage is offered to individuals under the program,
43 but may not offer benefits that cover any service for which coverage is
44 offered to individuals under the program. Provided, however, that this
45 subdivision shall not prohibit (a) the offering of any benefits to or
46 for individuals, including their families, who are employed or self-em-
47 ployed in the state but who are not residents of the state, or (b) the
48 offering of benefits during the implementation period to individuals who
49 enrolled or may enroll as members of the program, or (c) the offering of
50 retiree health benefits.

51 5. A college, university or other institution of higher education in
52 the state may purchase coverage under the program for any student, or
53 student's dependent, who is not a resident of the state.

54 6. To the extent any provision of this chapter, the social services
55 law, the insurance law or the elder law:

1 (a) is inconsistent with any provision of this article or the legisla-
2 tive intent of the New York Health Act, this article shall apply and
3 prevail, except where explicitly provided otherwise by this article; and

4 (b) is consistent with the provisions of this article and the legisla-
5 tive intent of the New York Health Act, the provision of that law shall
6 apply.

7 7. The program shall be deemed to be a health care plan for purposes
8 of utilization review and external appeal under article forty-nine of
9 this chapter. An enrollee may designate a person or entity, including,
10 but not limited to, a representative of the enrollee's care coordinator,
11 a health care organization providing the service under review or appeal,
12 or a labor union or Taft-Hartley fund of which such enrollee or
13 enrollee's family member is a member to serve as the enrollee's designee
14 for purposes of that article, if the person or entity agrees to be the
15 designee.

16 8. (a) No member shall be required to receive any health care service
17 through any entity organized, certified or operating under guidelines
18 under article forty-four of this chapter, or specified under section
19 three hundred sixty-four-j of the social services law, the insurance law
20 or the elder law. No such entity shall receive payment for health care
21 services (other than care coordination) from the program.

22 (b) However, this subdivision shall not preclude the use of a Medicare
23 managed care ("Medicare advantage") entity or other entity created by or
24 under the direction of the program where reasonably necessary to maxi-
25 mize federal financial participation or other federal financial support
26 under any federally-matched public health program, Medicare or the
27 Affordable Care Act. Any entity under this paragraph shall, to the maxi-
28 mum extent feasible, operate in the background, without burden on or
29 interference with the member and health care provider, without depriving
30 the member or health care provider of any right or benefit under the
31 program and otherwise consistent with this article.

32 9. The program shall include provisions for an appropriate reserve
33 fund.

34 10. (a) This subdivision applies to every person who is a retiree of a
35 public employer, as defined in section two hundred one of the civil
36 service law, and any person who is a beneficiary of the retiree's public
37 employee retiree health benefit. Any reference to the retiree shall mean
38 and include any beneficiary of the retiree. This subdivision does not
39 create or increase any eligibility for any public employee retiree
40 health benefit that would not otherwise exist and does not diminish any
41 public employee retiree health benefit.

42 (b) This paragraph applies to the retiree while he or she is a resi-
43 dent of New York state. The retiree shall enroll in the program. If, by
44 the implementation date, the retiree has not enrolled in the program,
45 the appropriate public employee retirement system and the commissioner
46 shall enroll the retiree in the New York Health program. If the
47 retiree's public employee retiree health benefit includes any service
48 for which coverage is not offered under the New York Health program, the
49 retiree shall continue to receive that benefit from the public employee
50 retirement program.

51 (c) For every retiree, while he or she is not a resident of New York
52 state, the appropriate public employee retirement system shall maintain
53 the retiree's public employee retiree health benefit as if this article
54 had not been enacted.

55 § 5102. Board of trustees. 1. The New York Health board of trustees is
56 hereby created in the department. The board of trustees shall, at the

1 request of the commissioner, consider any matter to effectuate the
2 provisions and purposes of this article, and may advise the commissioner
3 thereon; and it may, from time to time, submit to the commissioner any
4 recommendations to effectuate the provisions and purposes of this arti-
5 cle. The commissioner may propose regulations under this article and
6 amendments thereto for consideration by the board. The board of trustees
7 shall have no executive, administrative or appointive duties except as
8 otherwise provided by law. The board of trustees shall have power to
9 establish, and from time to time, amend regulations to effectuate the
10 provisions and purposes of this article, subject to approval by the
11 commissioner.

12 2. The board shall be composed of:

13 (a) the commissioner, the superintendent of financial services, and
14 the director of the budget, or their designees, as ex officio members;

15 (b) twenty-six trustees appointed by the governor;

16 (i) six of whom shall be representatives of health care consumer advoca-
17 cacy organizations which have a statewide or regional constituency, who
18 have been involved in issues of interest to low- and moderate-income
19 individuals, older adults, and people with disabilities; at least three
20 of whom shall represent organizations led by consumers in those groups;

21 (ii) two of whom shall be representatives of professional organiza-
22 tions representing physicians;

23 (iii) two of whom shall be representatives of professional organiza-
24 tions representing licensed or registered health care professionals
25 other than physicians;

26 (iv) three of whom shall be representatives of general hospitals, one
27 of whom shall be a representative of public general hospitals;

28 (v) one of whom shall be a representative of community health centers;

29 (vi) two of whom shall be representatives of rehabilitation or home
30 care providers;

31 (vii) two of whom shall be representatives of behavioral or mental
32 health or disability service providers;

33 (viii) two of whom shall be representatives of health care organiza-
34 tions;

35 (ix) two of whom shall be representatives of organized labor;

36 (x) two of whom shall have demonstrated expertise in health care
37 finance; and

38 (xi) two of whom shall be employers or representatives of employers
39 who pay the payroll tax under this article, or, prior to the tax becom-
40 ing effective, will pay the tax;

41 (c) fourteen trustees appointed by the governor; five of whom to be
42 appointed on the recommendation of the speaker of the assembly; five of
43 whom to be appointed on the recommendation of the temporary president of
44 the senate; two of whom to be appointed on the recommendation of the
45 minority leader of the assembly; and two of whom to be appointed on the
46 recommendation of the minority leader of the senate.

47 3. After the end of the implementation period, no person shall be a
48 trustee unless he or she is a member of the program, except the ex offi-
49 cio trustees. Each trustee shall serve at the pleasure of the appointing
50 officer, except the ex officio trustees.

51 4. The chair of the board shall be appointed, and may be removed as
52 chair, by the governor from among the trustees. The board shall meet at
53 least four times each calendar year. Meetings shall be held upon the
54 call of the chair and as provided by the board. A majority of the
55 appointed trustees shall be a quorum of the board, and the affirmative
56 vote of a majority of the trustees voting, but not less than ten, shall

1 be necessary for any action to be taken by the board. The board may
2 establish an executive committee to exercise any powers or duties of the
3 board as it may provide, and other committees to assist the board or the
4 executive committee. The chair of the board shall chair the executive
5 committee and shall appoint the chair and members of all other commit-
6 tees. The board of trustees may appoint one or more advisory committees.
7 Members of advisory committees need not be members of the board of trus-
8 tees.

9 5. Trustees shall serve without compensation but shall be reimbursed
10 for their necessary and actual expenses incurred while engaged in the
11 business of the board.

12 6. Notwithstanding any provision of law to the contrary, no officer or
13 employee of the state or any local government shall forfeit or be deemed
14 to have forfeited his or her office or employment by reason of being a
15 trustee.

16 7. The board and its committees and advisory committees may request
17 and receive the assistance of the department and any other state or
18 local governmental entity in exercising its powers and duties.

19 8. No later than two years after the effective date of this article:

20 (a) The board shall develop proposals for: (i) incorporating retiree
21 health benefits into New York Health; (ii) accommodating employer reti-
22 ree health benefits for people who have been members of New York Health
23 but live as retirees out of the state; and (iii) accommodating employer
24 retiree health benefits for people who earned or accrued such benefits
25 while residing in the state prior to the implementation of New York
26 Health and live as retirees out of the state. The board shall present
27 its proposals to the governor and the legislature.

28 (b) The board shall develop a proposal for New York Health coverage of
29 health care services covered under the workers' compensation law,
30 including whether and how to continue funding for those services under
31 that law and whether and how to incorporate an element of experience
32 rating.

33 § 5103. Eligibility and enrollment. 1. Every resident of the state
34 shall be eligible and entitled to enroll as a member under the program.

35 2. No individual shall be required to pay any premium or other charge
36 for enrolling in or being a member under the program.

37 3. A newborn child shall be enrolled as of the date of the child's
38 birth if enrollment is done prior to the child's birth or within sixty
39 days after the child's birth.

40 § 5104. Benefits. 1. The program shall provide comprehensive health
41 coverage to every member, which shall include all health care services
42 required to be covered under any of the following, without regard to
43 whether the member would otherwise be eligible for or covered by the
44 program or source referred to:

45 (a) child health plus;

46 (b) Medicaid;

47 (c) Medicare;

48 (d) article forty-four of this chapter or article thirty-two or
49 forty-three of the insurance law;

50 (e) article eleven of the civil service law, as of the date one year
51 before the beginning of the implementation period;

52 (f) any cost incurred defined in paragraph one of subsection (a) of
53 section fifty-one hundred two of the insurance law, provided that this
54 coverage shall not replace coverage under article fifty-one of the
55 insurance law;

1 (g) any additional health care service authorized to be added to the
2 program's benefits by the program; and

3 (h) provided that where any state law or regulation related to any
4 federally-matched public health program states that a benefit is contin-
5 gent on federal financial participation, or words to that effect, the
6 benefit shall be included under the New York Health program without
7 regard to federal financial participation.

8 2. No member shall be required to pay any premium, deductible, co-pay-
9 ment or co-insurance under the program.

10 3. The program shall provide for payment under the program for:

11 (a) emergency and temporary health care services provided to a member
12 or individual entitled to become a member who has not had a reasonable
13 opportunity to become a member or to enroll with a care coordinator; and

14 (b) health care services provided in an emergency to an individual who
15 is entitled to become a member or enrolled with a care coordinator,
16 regardless of having had an opportunity to do so.

17 § 5105. Health care providers; care coordination; payment methodol-
18 ogies. 1. Choice of health care provider. (a) Any health care provider
19 qualified to participate under this section may provide health care
20 services under the program, provided that the health care provider is
21 otherwise legally authorized to perform the health care service for the
22 individual and under the circumstances involved.

23 (b) A member may choose to receive health care services under the
24 program from any participating provider, consistent with provisions of
25 this article relating to care coordination and health care organiza-
26 tions, the willingness or availability of the provider (subject to
27 provisions of this article relating to discrimination), and the appro-
28 priate clinically-relevant circumstances.

29 2. Care coordination. (a) A care coordinator may be an individual or
30 entity that is approved by the program that is:

31 (i) a health care practitioner who is: (A) the member's primary care
32 practitioner; (B) at the option of a female member, the member's provid-
33 er of primary gynecological care; or (C) at the option of a member who
34 has a chronic condition that requires specialty care, a specialist
35 health care practitioner who regularly and continually provides treat-
36 ment for that condition to the member;

37 (ii) an entity licensed under article twenty-eight of this chapter or
38 certified under article thirty-six of this chapter, or, with respect to
39 a member who receives chronic mental health care services, an entity
40 licensed under article thirty-one of the mental hygiene law or other
41 entity approved by the commissioner in consultation with the commission-
42 er of mental health;

43 (iii) a health care organization;

44 (iv) a Taft-Hartley fund or labor union, with respect to its members
45 and their family members; provided that this provision shall not
46 preclude a Taft-Hartley fund or labor union from becoming a care coordi-
47 nator under subparagraph (v) of this paragraph or a health care organ-
48 ization under section fifty-one hundred six of this article; or

49 (v) any not-for-profit or governmental entity approved by the program.

50 (b)(i) Every member shall enroll with a care coordinator that agrees
51 to provide care coordination to the member prior to receiving health
52 care services to be paid for under the program. Health care services
53 provided to a member shall not be subject to payment under the program
54 unless the member is enrolled with a care coordinator at the time the
55 health care service is provided.

1 (ii) This paragraph shall not apply to health care services provided
2 under subdivision three of section fifty-one hundred four of this arti-
3 cle.

4 (iii) The member shall remain enrolled with that care coordinator
5 until the member becomes enrolled with a different care coordinator or
6 ceases to be a member. Members have the right to change their care coor-
7 dinators on terms at least as permissive as the provisions of section
8 three hundred sixty-four-j of the social services law relating to an
9 individual changing his or her primary care provider or managed care
10 provider.

11 (c) Care coordination shall be provided to the member by the member's
12 care coordinator. A care coordinator may employ or utilize the services
13 of other individuals or entities to assist in providing care coordi-
14 nation for the member, consistent with regulations of the commissioner.

15 (d) A health care organization may establish rules relating to care
16 coordination for members in the health care organization, different from
17 this subdivision but otherwise consistent with this article and other
18 applicable laws.

19 (e) The commissioner shall develop and implement procedures and stand-
20 ards for an individual or entity to be approved to be a care coordinator
21 in the program, including but not limited to procedures and standards
22 relating to the revocation, suspension, limitation, or annulment of
23 approval on a determination that the individual or entity is not compe-
24 tent to be a care coordinator or has exhibited a course of conduct which
25 is either inconsistent with program standards and regulations or which
26 exhibits an unwillingness to meet such standards and regulations, or is
27 a potential threat to the public health or safety. Such procedures and
28 standards shall not limit approval to be a care coordinator in the
29 program for economic purposes and shall be consistent with good profes-
30 sional practice. In developing the procedures and standards, the commis-
31 sioner shall: (i) consider existing standards developed by national
32 accrediting and professional organizations; and (ii) consult with
33 national and local organizations working on care coordination or similar
34 models, including health care practitioners, hospitals, clinics, and
35 consumers and their representatives. When developing and implementing
36 standards of approval of care coordinators for individuals receiving
37 chronic mental health care services, the commissioner shall consult with
38 the commissioner of mental health. An individual or entity may not be a
39 care coordinator unless the services included in care coordination are
40 within the individual's professional scope of practice or the entity's
41 legal authority.

42 (f) To maintain approval under the program, a care coordinator must:
43 (i) renew its status at a frequency determined by the commissioner; and
44 (ii) provide data to the department as required by the commissioner to
45 enable the commissioner to evaluate the impact of care coordinators on
46 quality, outcomes and cost.

47 (g) Nothing in this subdivision shall authorize any individual to
48 engage in any act in violation of title eight of the education law.

49 3. Health care providers. (a) The commissioner shall establish and
50 maintain procedures and standards for health care providers to be quali-
51 fied to participate in the program, including but not limited to proce-
52 dures and standards relating to the revocation, suspension, limitation,
53 or annulment of qualification to participate on a determination that the
54 health care provider is not competent to be a provider of specific
55 health care services or has exhibited a course of conduct which is
56 either inconsistent with program standards and regulations or which

1 exhibits an unwillingness to meet such standards and regulations, or is
2 a potential threat to the public health or safety. Such procedures and
3 standards shall not limit health care provider participation in the
4 program for economic purposes and shall be consistent with good profes-
5 sional practice. Such procedures and standards may be different for
6 different types of health care providers and health care professionals.
7 Any health care provider who is qualified to participate under Medicaid,
8 child health plus or Medicare shall be deemed to be qualified to partic-
9 ipate in the program, and any health care provider's revocation, suspen-
10 sion, limitation, or annulment of qualification to participate in any of
11 those programs shall apply to the health care provider's qualification
12 to participate in the program; provided that a health care provider
13 qualified under this sentence shall follow the procedures to become
14 qualified under the program by the end of the implementation period.

15 (b) The commissioner shall establish and maintain procedures and stan-
16 dards for recognizing health care providers located out of the state for
17 purposes of providing coverage under the program for out-of-state health
18 care services.

19 (c) Procedures and standards under this subdivision shall include
20 provisions for expedited temporary qualification to participate in the
21 program for health care professionals who are (i) temporarily authorized
22 to practice in the state or (ii) are recently arrived in the state or
23 recently authorized to practice in the state.

24 4. Payment for health care services. (a) The commissioner may estab-
25 lish by regulation payment methodologies for health care services and
26 care coordination provided to members under the program by participating
27 providers, care coordinators, and health care organizations. There may
28 be a variety of different payment methodologies, including those estab-
29 lished on a demonstration basis. All payment rates under the program
30 shall be reasonable and reasonably related to the cost of efficiently
31 providing the health care service and assuring an adequate and accessi-
32 ble supply of the health care service. Until and unless another payment
33 methodology is established, health care services provided to members
34 under the program shall be paid for on a fee-for-service basis, except
35 for care coordination.

36 (b) The program shall engage in good faith negotiations with health
37 care providers' representatives under title III of article forty-nine of
38 this chapter, including, but not limited to, in relation to rates of
39 payment and payment methodologies.

40 (c) Notwithstanding any provision of law to the contrary, payment for
41 drugs provided by pharmacies under the program shall be made pursuant to
42 title one of article two-A of this chapter. However, the program shall
43 provide for payment for prescription drugs under section 340B of the
44 federal public service act where applicable. Payment for prescription
45 drugs provided by health care providers other than pharmacies shall be
46 pursuant to other provisions of this article.

47 (d) Payment for health care services established under this article
48 shall be considered payment in full. A participating provider shall not
49 charge any rate in excess of the payment established under this article
50 for any health care service provided under the program and shall not
51 solicit or accept payment from any member or third party for any such
52 service except as provided under section fifty-one hundred nine of this
53 article. However, this paragraph shall not preclude the program from
54 acting as a primary or secondary payer in conjunction with another
55 third-party payer where permitted under section fifty-one hundred nine
56 of this article.

1 (e) The program may provide in payment methodologies for payment for
2 capital related expenses for specifically identified capital expendi-
3 tures incurred by not-for-profit or governmental entities certified
4 under article twenty-eight of this chapter. Any capital related expense
5 generated by a capital expenditure that requires or required approval
6 under article twenty-eight of this chapter must have received that
7 approval for the capital related expense to be paid for under the
8 program.

9 (f) Payment methodologies and rates shall include a distinct component
10 of reimbursement for direct and indirect graduate medical education as
11 defined, calculated and implemented pursuant to section twenty-eight
12 hundred seven-c of this chapter.

13 (g) The commissioner shall provide by regulation for payment method-
14 ologies and procedures for paying for out-of-state health care services.

15 5. Prior authorization. The program shall not require prior authori-
16 zation for any health care service in any manner more restrictive of
17 access to or payment for the service than would be required for the
18 service under Medicare Part A or Part B. Prior authorization for
19 prescription drugs provided by pharmacies under the program shall be
20 under title one of article two-A of this chapter.

21 § 5106. Health care organizations. 1. A member may choose to enroll
22 with and receive health care services under the program from a health
23 care organization.

24 2. A health care organization shall be a not-for-profit or govern-
25 mental entity that is approved by the commissioner that is:

26 (a) an accountable care organization under article twenty-nine-E of
27 this chapter; or

28 (b) a Taft-Hartley fund (i) with respect to its members and their
29 family members, and (ii) if allowed by applicable law and approved by
30 the commissioner, for other members of the program.

31 3. A health care organization may be responsible for providing all or
32 part of the health care services to which its members are entitled under
33 the program, consistent with the terms of its approval by the commis-
34 sioner.

35 4. (a) The commissioner shall develop and implement procedures and
36 standards for an entity to be approved to be a health care organization
37 in the program, including but not limited to procedures and standards
38 relating to the revocation, suspension, limitation, or annulment of
39 approval on a determination that the entity is not competent to be a
40 health care organization or has exhibited a course of conduct which is
41 either inconsistent with program standards and regulations or which
42 exhibits an unwillingness to meet such standards and regulations, or is
43 a potential threat to the public health or safety. Such procedures and
44 standards shall not limit approval to be a health care organization in
45 the program for economic purposes and shall be consistent with good
46 professional practice. In developing the procedures and standards, the
47 commissioner shall: (i) consider existing standards developed by
48 national accrediting and professional organizations; and (ii) consult
49 with national and local organizations working in the field of health
50 care organizations, including health care practitioners, hospitals,
51 clinics, long-term supports and service providers, consumers and their
52 representatives and labor organizations representing health care work-
53 ers. When developing and implementing standards of approval of health
54 care organizations, the commissioner shall consult with the commissioner
55 of mental health, the commissioner of developmental disabilities, the

1 director of the state office for the aging and the commissioner of the
2 office of alcoholism and substance abuse services.

3 (b) To maintain approval under the program, a health care organization
4 must: (i) renew its status at a frequency determined by the commis-
5 sioner; and (ii) provide data to the department as required by the commis-
6 sioner to enable the commissioner to evaluate the health care organiza-
7 tion in relation to quality of health care services, health care
8 outcomes, and cost.

9 5. The commissioner shall make regulations relating to health care
10 organizations consistent with and to ensure compliance with this arti-
11 cle.

12 6. The provision of health care services directly or indirectly by a
13 health care organization through health care providers shall not be
14 considered the practice of a profession under title eight of the educa-
15 tion law by the health care organization.

16 § 5107. Program standards. 1. The commissioner shall establish
17 requirements and standards for the program and for health care organiza-
18 tions, care coordinators, and health care providers, consistent with
19 this article, including requirements and standards for, as applicable:

20 (a) the scope, quality and accessibility of health care services;

21 (b) relations between health care organizations or health care provid-
22 ers and members; and

23 (c) relations between health care organizations and health care
24 providers, including (i) credentialing and participation in the health
25 care organization; and (ii) terms, methods and rates of payment.

26 2. Requirements and standards under the program shall include, but not
27 be limited to, provisions to promote the following:

28 (a) simplification, transparency, uniformity, and fairness in health
29 care provider credentialing and participation in health care organiza-
30 tion networks, referrals, payment procedures and rates, claims process-
31 ing, and approval of health care services, as applicable;

32 (b) primary and preventive care, care coordination, efficient and
33 effective health care services, quality assurance, coordination and
34 integration of health care services, including use of appropriate tech-
35 nology, and promotion of public, environmental and occupational health;

36 (c) elimination of health care disparities;

37 (d) non-discrimination with respect to members and health care provid-
38 ers on the basis of race, ethnicity, national origin, religion, disabil-
39 ity, age, sex, sexual orientation, gender identity or expression, or
40 economic circumstances; provided that health care services provided
41 under the program shall be appropriate to the patient's clinically-rele-
42 vant circumstances;

43 (e) accessibility of care coordination, health care organization
44 services and health care services, including accessibility for people
45 with disabilities and people with limited ability to speak or understand
46 English, and the providing of care coordination, health care organiza-
47 tion services and health care services in a culturally competent manner;
48 and

49 (f) especially in relation to long-term supports and services, the
50 maximization and prioritization of the most integrated community-based
51 supports and services.

52 3. Any participating provider or care coordinator that is organized as
53 a for-profit entity (other than a professional practice of one or more
54 health care professionals) shall be required to meet the same require-
55 ments and standards as entities organized as not-for-profit entities,
56 and payments under the program paid to such entities shall not be calcu-

lated to accommodate the generation of profit or revenue for dividends or other return on investment or the payment of taxes that would not be paid by a not-for-profit entity.

4. Every participating provider shall furnish to the program such information to, and permit examination of its records by, the program, as may be reasonably required for purposes of reviewing accessibility and utilization of health care services, quality assurance, promoting improved patient outcomes and cost containment, the making of payments, and statistical or other studies of the operation of the program or for protection and promotion of public, environmental and occupational health.

5. In developing requirements and standards and making other policy determinations under this article, the commissioner shall consult with representatives of members, health care providers, care coordinators, health care organizations employers, organized labor including representatives of health care workers, and other interested parties.

6. The program shall maintain the security and confidentiality of all data and other information collected under the program when such data would be normally considered confidential patient data. Aggregate data of the program which is derived from confidential data but does not violate patient confidentiality shall be public information including for purposes of article six of the public officers law.

§ 5108. Regulations. The commissioner may make regulations under this article by approving regulations and amendments thereto, under subdivision one of section fifty-one hundred two of this article. The commissioner may make regulations or amendments thereto under this article on an emergency basis under section two hundred two of the state administrative procedure act, provided that such regulations or amendments shall not become permanent unless adopted under subdivision one of section fifty-one hundred two of this article.

§ 5109. Provisions relating to federal health programs. 1. The commissioner shall seek all federal waivers and other federal approvals and arrangements and submit state plan amendments necessary to operate the program consistent with this article to the maximum extent possible.

2. (a) The commissioner shall apply to the secretary of health and human services or other appropriate federal official for all waivers of requirements, and make other arrangements, under Medicare, any federally-matched public health program, the affordable care act, and any other federal programs that provide federal funds for payment for health care services, that are necessary to enable all New York Health members to receive all benefits under the program through the program to enable the state to implement this article and to receive and deposit all federal payments under those programs (including funds that may be provided in lieu of premium tax credits, cost-sharing subsidies, and small business tax credits) in the state treasury to the credit of the New York Health trust fund and to use those funds for the New York Health program and other provisions under this article. To the extent possible, the commissioner shall negotiate arrangements with the federal government in which bulk or lump-sum federal payments are paid to New York Health in place of federal spending or tax benefits for federally-matched health programs or federal health programs. The commissioner shall take actions under paragraph (b) of subdivision eight of section fifty-one hundred one of this article as reasonably necessary.

(b) The commissioner may require members or applicants to be members to provide information necessary for the program to comply with any waiver or arrangement under this subdivision.

1 3. (a) The commissioner may take actions consistent with this article
2 to enable New York Health to administer Medicare in New York state, to
3 create a Medicare managed care plan ("Medicare Advantage") that would
4 operate consistent with this article, and to be a provider of drug
5 coverage under Medicare part D for eligible members of New York Health.

6 (b) The commissioner may waive or modify the applicability of
7 provisions of this section relating to any federally-matched public
8 health program or Medicare as necessary to implement any waiver or
9 arrangement under this section or to maximize the benefit to the New
10 York Health program under this section, provided that the commissioner,
11 in consultation with the director of the budget, shall determine that
12 such waiver or modification is in the best interests of the members
13 affected by the action and the state.

14 (c) The commissioner may apply for coverage under any federally-
15 matched public health program on behalf of any member and enroll the
16 member in the federally-matched public health program or Medicare if the
17 member is eligible for it. Enrollment in a federally-matched public
18 health program or Medicare shall not cause any member to lose any health
19 care service provided by the program or diminish any right the member
20 would otherwise have.

21 (d) The commissioner shall by regulation increase the income eligibil-
22 ity level, increase or eliminate the resource test for eligibility,
23 simplify any procedural or documentation requirement for enrollment, and
24 increase the benefits for any federally-matched public health program,
25 and for any program to reduce or eliminate an individual's coinsurance,
26 cost-sharing or premium obligations or increase an individual's eligi-
27 bility for any federal financial support related to Medicare or the
28 affordable care act notwithstanding any law or regulation to the contra-
29 ry. The commissioner may act under this paragraph upon a finding,
30 approved by the director of the budget, that the action (i) will help to
31 increase the number of members who are eligible for and enrolled in
32 federally-matched public health programs, or for any program to reduce
33 or eliminate an individual's coinsurance, cost-sharing or premium obli-
34 gations or increase an individual's eligibility for any federal finan-
35 cial support related to Medicare or the affordable care act; (ii) will
36 not diminish any individual's access to any health care service, benefit
37 or right the individual would otherwise have; (iii) is in the interest
38 of the program; and (iv) does not require or has received any necessary
39 federal waivers or approvals to ensure federal financial participation.

40 (e) To enable the commissioner to apply for coverage or financial
41 support under any federally-matched public health program, the Afforda-
42 ble Care Act, or Medicare on behalf of any member and enroll the member
43 in any such program, including an entity under paragraph (b) of subdivi-
44 sion eight of section fifty-one hundred one of this article if the
45 member is eligible for it, the commissioner may require that every
46 member or applicant to be a member shall provide information to enable
47 the commissioner to determine whether the applicant is eligible for such
48 program. The program shall make a reasonable effort to notify members
49 of their obligations under this paragraph. After a reasonable effort has
50 been made to contact the member, the member shall be notified in writing
51 that he or she has sixty days to provide such required information. If
52 such information is not provided within the sixty day period, the
53 member's coverage under the program may be terminated.

54 (f) To the extent necessary for purposes of this section, as a condi-
55 tion of continued eligibility for health care services under the

1 program, a member who is eligible for benefits under Medicare shall
2 enroll in Medicare, including parts A, B and D.

3 (g) The program shall provide premium assistance for all members
4 enrolling in a Medicare part D drug coverage under section 1860D of
5 Title XVIII of the federal social security act limited to the low-income
6 benchmark premium amount established by the federal centers for Medicare
7 and Medicaid services and any other amount which such agency establishes
8 under its de minimis premium policy, except that such payments made on
9 behalf of members enrolled in a Medicare advantage plan may exceed the
10 low-income benchmark premium amount if determined to be cost effective
11 to the program.

12 (h) If the commissioner has reasonable grounds to believe that a
13 member could be eligible for an income-related subsidy under section
14 1860D-14 of Title XVIII of the federal social security act, the member
15 shall provide, and authorize the program to obtain, any information or
16 documentation required to establish the member's eligibility for such
17 subsidy, provided that the commissioner shall attempt to obtain as much
18 of the information and documentation as possible from records that are
19 available to him or her.

20 (i) The program shall make a reasonable effort to notify members of
21 their obligations under this subdivision. After a reasonable effort has
22 been made to contact the member, the member shall be notified in writing
23 that he or she has sixty days to provide such required information. If
24 such information is not provided within the sixty day period, the
25 member's coverage under the program may be terminated.

26 § 5110. Additional provisions. 1. The commissioner shall contract
27 with not-for-profit organizations to provide:

28 (a) consumer assistance to individuals with respect to selection and
29 changing selection of a care coordinator or health care organization,
30 enrolling, obtaining health care services, and other matters relating to
31 the program;

32 (b) health care provider assistance to health care providers providing
33 and seeking or considering whether to provide, health care services
34 under the program, with respect to participating in a health care organ-
35 ization and dealing with a health care organization; and

36 (c) care coordinator assistance to individuals and entities providing
37 and seeking or considering whether to provide, care coordination to
38 members.

39 2. The commissioner shall provide grants from funds in the New York
40 Health trust fund or otherwise appropriated for this purpose, to health
41 systems agencies under section twenty-nine hundred four-b of this chap-
42 ter to support the operation of such health systems agencies.

43 3. Retraining and re-employment of impacted employees. (a) As used in
44 this subdivision:

45 (i) "Third party payer" means an insurer authorized to provide health
46 coverage under the insurance law, a health maintenance organization
47 under article forty-four of this chapter, a self-insured plan providing
48 health coverage, or any other third party payer for health care
49 services.

50 (ii) "Health care provider administrative employee" means an employee
51 of a health care provider primarily engaged in relations or dealings
52 with third party payers or seeking payment or reimbursement for health
53 care services from third party payers.

54 (iii) "Impacted employee" means an individual who, at any time from
55 the date this section becomes a law until two years after the end of the
56 implementation period, is employed by a third party payer or is a health

1 care provider administrative employee, and whose employment ends as a
2 result of the implementation of the New York Health program.

3 (b) Within ninety days after this section shall become a law, the
4 commissioner of labor shall convene a retraining and re-employment task
5 force including but not limited to: representatives of potential
6 impacted employees, human resource departments of third party payers and
7 health care providers, individuals with experience and expertise in
8 retraining and re-employment programs relevant to the circumstances of
9 impacted employees, and representatives of the commissioner of labor.
10 The commissioner of labor and the task force shall review and provide:

11 (i) analysis of potential impacted employees by job title and
12 geography;

13 (ii) competency mapping and labor market analysis of impacted employee
14 occupations with job openings; and

15 (iii) establishment of regional retraining and re-employment systems,
16 including but not limited to job boards, outplacement services, job
17 search services, career advisement services, and retraining advisement,
18 to be coordinated with the regional advisory councils established under
19 section fifty-one hundred eleven of this article.

20 (c) (i) Three or more impacted employees, a recognized union of work-
21 ers including impacted employees, or an employer of impacted employees
22 may file a petition with the commissioner of labor to certify such
23 employees as being impacted employees.

24 (ii) Impacted employees shall be eligible for:

25 (A) up to two years of retraining at any training provider approved by
26 the commissioner of labor; and

27 (B) up to two years of unemployment benefits, provided that the
28 impacted employee is enrolled in a department of labor approved training
29 program, is actively seeking employment, and is not currently employed
30 full time; provided, however, that such impacted employee may maintain
31 unemployment benefits for up to two years even if he or she does not
32 meet the criteria set forth in this clause but is sixty-three years of
33 age or older at the time of loss of employment as an impacted employee.

34 (d) The commissioner shall provide funds from the New York Health
35 trust fund or otherwise appropriated for this purpose to the commission-
36 er of labor for retraining and re-employment programs for impacted
37 employees under this subdivision.

38 (e) The commissioner of labor shall make regulations and take other
39 actions reasonably necessary to implement this subdivision. This subdivi-
40 vision shall be implemented consistent with applicable law and regu-
41 lations.

42 4. The commissioner shall, directly and through grants to not-for-pro-
43 fit entities, conduct programs using data collected through the New York
44 Health program, to promote and protect the quality of health care
45 services, patient outcomes, and public, environmental and occupational
46 health, including cooperation with other data collection and research
47 programs of the department, consistent with this article, the protection
48 of the security and confidentiality of individually identifiable patient
49 information, and otherwise applicable law.

50 § 5111. Regional advisory councils. 1. The New York Health regional
51 advisory councils (each referred to in this article as a "regional advi-
52 sory council") are hereby created in the department.

53 2. There shall be a regional advisory council established in each of
54 the following regions:

55 (a) Long Island, consisting of Nassau and Suffolk counties;

56 (b) New York City;

1 (c) Hudson Valley, consisting of Delaware, Dutchess, Orange, Putnam,
2 Rockland, Sullivan, Ulster, Westchester counties;

3 (d) Northern, consisting of Albany, Clinton, Columbia, Essex, Frank-
4 lin, Fulton, Greene, Hamilton, Herkimer, Jefferson, Lewis, Montgomery,
5 Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, St. Lawrence,
6 Warren, Washington counties;

7 (e) Central, consisting of Broome, Cayuga, Chemung, Chenango, Cort-
8 land, Livingston, Madison, Monroe, Oneida, Onondaga, Ontario, Oswego,
9 Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne, Yates counties; and

10 (f) Western, consisting of Allegany, Cattaraugus, Chautauqua, Erie,
11 Genesee, Niagara, Orleans, Wyoming counties.

12 3. Each regional advisory council shall be composed of not fewer than
13 twenty-seven members, as determined by the commissioner and the board,
14 as necessary to appropriately represent the diverse needs and concerns
15 of the region. Members of a regional advisory council shall be residents
16 of or have their principal place of business in the region served by the
17 regional advisory council.

18 4. Appointment of members of the regional advisory councils.

19 (a) The twenty-seven members shall be appointed as follows:

20 (i) nine members shall be appointed by the governor;

21 (ii) six members shall be appointed by the governor on the recommenda-
22 tion of the speaker of the assembly;

23 (iii) six members shall be appointed by the governor on the recommen-
24 dation of the temporary president of the senate;

25 (iv) three members shall be appointed by the governor on the recommen-
26 dation of the minority leader of the assembly; and

27 (v) three members shall be appointed by the governor on the recommen-
28 dation of the minority leader of the senate.

29 Where a regional advisory council has more than twenty-seven members,
30 additional members shall be appointed and recommended by these officials
31 in the same proportion as the twenty-seven members.

32 (b) Regional advisory council membership shall include but not be
33 limited to:

34 (i) representatives of organizations with a regional constituency that
35 advocate for health care consumers, older adults, and people with disa-
36 bilities including organizations led by members of those groups, who
37 shall constitute at least one third of the membership of each regional
38 council;

39 (ii) representatives of professional organizations representing physi-
40 cians;

41 (iii) representatives of professional organizations representing
42 health care professionals other than physicians;

43 (iv) representatives of general hospitals, including public hospitals;

44 (v) representatives of community health centers;

45 (vi) representatives of mental health, behavioral health (including
46 substance use), physical disability, developmental disability, rehabili-
47 tation, home care and other service providers;

48 (vii) representatives of women's health service providers;

49 (viii) representatives of health care organizations;

50 (ix) representatives of organized labor including representatives of
51 health care workers;

52 (x) representatives of employers; and

53 (xi) representatives of municipal and county government.

54 5. Members of a regional advisory council shall be appointed for terms
55 of three years provided, however, that of the members first appointed,
56 one-third shall be appointed for one year terms and one-third shall be

1 appointed for two year terms. Vacancies shall be filled in the same
2 manner as original appointments for the remainder of any unexpired term.
3 No person shall be a member of a regional advisory council for more than
4 six years in any period of twelve consecutive years.

5 6. Members of the regional advisory councils shall serve without
6 compensation but shall be reimbursed for their necessary and actual
7 expenses incurred while engaged in the business of the advisory coun-
8 cils. The program shall provide financial support for such expenses and
9 other expenses of the regional advisory councils.

10 7. Each regional advisory council shall meet at least quarterly. Each
11 regional advisory council may form committees to assist it in its work.
12 Members of a committee need not be members of the regional advisory
13 council. The New York City regional advisory council shall form a
14 committee for each borough of New York City, to assist the regional
15 advisory council in its work as it relates particularly to that borough.

16 8. Each regional advisory council shall advise the commissioner, the
17 board, the governor and the legislature on all matters relating to the
18 development and implementation of the New York Health program.

19 9. Each regional advisory council shall adopt, and from time to time
20 revise, a community health improvement plan for its region for the
21 purpose of:

22 (a) promoting the delivery of health care services in the region,
23 improving the quality and accessibility of care, including cultural
24 competency, clinical integration of care between service providers
25 including but not limited to physical, mental, and behavioral health,
26 physical and developmental disability services, and long-term supports
27 and services;

28 (b) facility and health services planning in the region;

29 (c) identifying gaps in regional health care services;

30 (d) promoting increased public knowledge and responsibility regarding
31 the availability and appropriate utilization of health care services.
32 Each community health improvement plan shall be submitted to the commis-
33 sioner and the board and shall be posted on the department's website;

34 (e) identifying needs in professional and service personnel required
35 to deliver health care services; and

36 (f) coordinating regional implementation of retraining and re-employ-
37 ment programs for impacted employees under subdivision three of section
38 fifty-one hundred ten of this article.

39 10. Each regional advisory council shall hold at least four public
40 hearings annually on matters relating to the New York Health program and
41 the development and implementation of the community health improvement
42 plan.

43 11. Each regional advisory council shall publish an annual report to
44 the commissioner and the board on the progress of the community health
45 improvement plan. These reports shall be posted on the department's
46 website.

47 12. All meetings of the regional advisory councils and committees
48 shall be subject to article six of the public officers law.

49 § 4. Financing of New York Health. 1. The governor shall submit to the
50 legislature a revenue plan and legislative bills to implement the plan
51 (referred to collectively in this section as the "revenue proposal") to
52 provide the revenue necessary to finance the New York Health program, as
53 created by article 51 of the public health law and all provisions of
54 that article (referred to in this section as the "program"), taking into
55 consideration anticipated federal revenue available for the program. The
56 revenue proposal shall be submitted to the legislature as part of the

1 executive budget under article VII of the state constitution, for the
2 fiscal year commencing on the first day of April in the calendar year
3 after this act shall become a law. In developing the revenue proposal,
4 the governor shall consult with appropriate officials of the executive
5 branch; the temporary president of the senate; the speaker of the assem-
6 bly; the chairs of the fiscal and health committees of the senate and
7 assembly; and representatives of business, labor, consumers and local
8 government.

9 2. (a) Basic structure. The basic structure of the revenue proposal
10 shall be as follows: Revenue for the program shall come from two taxes
11 (referred to collectively in this section as the "taxes"). First, there
12 shall be a progressively graduated tax on all payroll and self-employed
13 income (referred to in this section as the "payroll tax"), paid by
14 employers, employees and self-employed individuals. Second, there shall
15 be a progressively graduated tax on taxable income (such as interest,
16 dividends, and capital gains) not subject to the payroll tax (referred
17 to in this section as the "non-payroll tax"). Income in the bracket
18 below twenty-five thousand dollars per year shall be exempt from the
19 taxes. Higher brackets of income subject to the taxes shall be assessed
20 at a higher marginal rate than lower brackets. The taxes shall be set
21 at levels anticipated to produce sufficient revenue to finance the
22 program, to be scaled up as enrollment grows, taking into consideration
23 anticipated federal revenue available for the program. Provision shall
24 be made for state residents (who are eligible for the program) who are
25 employed out-of-state, and non-residents (who are not eligible for the
26 program) who are employed in the state.

27 (b) Payroll tax. The income to be subject to the payroll tax shall be
28 all income subject to the Medicare Part A tax. The tax shall be set at a
29 percentage of that income, which shall be progressively graduated, so
30 the percentage is higher on higher brackets of income. For employed
31 individuals, the employer shall pay eighty percent of the tax and the
32 employee shall pay twenty percent of the tax, except that an employer
33 may agree to pay all or part of the employee's share. A self-employed
34 individual shall pay the full tax.

35 (c) Non-payroll income tax. There shall be a tax on income that is
36 subject to the personal income tax under article 22 of the tax law and
37 is not subject to the payroll tax. It shall be set at a percentage of
38 that income, which shall be progressively graduated, so the percentage
39 is higher on higher brackets of income.

40 (d) Phased-in rates. Early in the program, when enrollment is growing,
41 the amount of the taxes shall be at an appropriate level, and shall be
42 changed as anticipated enrollment grows, to cover the actual cost of the
43 program. The revenue proposal shall include a mechanism for determining
44 the rates of the taxes.

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

53 (ii) Out-of-state residents employed in the state. (A) The payroll
54 tax shall apply to any out-of-state resident who is employed or self-em-
55 ployed in the state. (B) In the case of an out-of-state resident who is
56 employed or self-employed in the state, such individual and individual's

1 employer shall be able to take a credit against the payroll taxes each
2 would otherwise pay as to that individual for amounts they spend respec-
3 tively on health benefits for the individual that would otherwise be
4 covered by the program if the individual were a member of the program.
5 For the employer, the credit shall be available regardless of the form
6 of the health benefit (e.g., health insurance, a self-insured plan,
7 direct services, or reimbursement for services), to make sure that the
8 revenue proposal does not relate to employment benefits in violation of
9 the federal ERISA. For non-employment-based spending by the individual,
10 the credit shall be available for and limited to spending for health
11 coverage (not out-of-pocket health spending). The credit shall be avail-
12 able without regard to how little is spent or how sparse the benefit.
13 The credit may only be taken against the payroll tax. Any excess amount
14 may not be applied to other tax liability. The credit shall be distrib-
15 uted between the employer and employee in the same proportion as the
16 spending by each for the benefit and may be applied to their respective
17 portion of the tax. (C) If any provision of this subparagraph or any
18 application of it shall be ruled to violate federal ERISA, the provision
19 or the application of it shall be null and void and the ruling shall not
20 affect any other provision or application of this section or the act
21 that enacted it.

22 3. (a) The revenue proposal shall include a plan and legislative
23 provisions for ending the requirement for local social services
24 districts to pay part of the cost of Medicaid and replacing those
25 payments with revenue from the taxes under the revenue proposal.

26 (b) The taxes under this section shall not supplant the spending of
27 other state revenue to pay for the Medicaid program as it exists as of
28 the enactment of the revenue proposal as amended, unless the revenue
29 proposal as amended provides otherwise.

30 4. To the extent that the revenue proposal differs from the terms of
31 subdivision two or paragraph (b) of subdivision three of this section,
32 the revenue proposal shall state how it differs from those terms and
33 reasons for and the effects of the differences.

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

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

38 TITLE III

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

41 Section 4920. Definitions.

42 4921. Collective negotiation authorized.

43 4922. Collective negotiation requirements.

44 4923. Requirements for health care providers' representative.

45 4924. Mediation.

46 4925. Certain collective action prohibited.

47 4926. Fees.

48 4927. Confidentiality.

49 4928. Severability and construction.

50 § 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

1 New York Health over terms and conditions affecting those health care
2 providers.

3 4. "Strike" means a work stoppage in part or in whole, direct or indi-
4 rect, by a body of workers to gain compliance with demands made on an
5 employer.

6 5. "Health care provider" means a health care provider under article
7 fifty-one of this chapter. A health care professional as defined in
8 article fifty-one of this chapter who practices as an employee or inde-
9 pendent contractor of another health care provider shall not be deemed a
10 health care provider for purposes of this title.

11 § 4921. Collective negotiation authorized. 1. Health care providers
12 may meet and communicate for the purpose of collectively negotiating
13 with New York Health on any matter relating to New York Health, includ-
14 ing but not limited to rates of payment and payment methodologies.

15 2. Nothing in this section shall be construed to allow or authorize an
16 alteration of the terms of the internal and external review procedures
17 set forth in law.

18 3. Nothing in this section shall be construed to allow a strike of New
19 York Health by health care providers.

20 4. Nothing in this section shall be construed to allow or authorize
21 terms or conditions which would impede the ability of New York Health to
22 obtain or retain accreditation by the national committee for quality
23 assurance or a similar body or to comply with applicable state or feder-
24 al law.

25 § 4922. Collective negotiation requirements. 1. Collective negotiation
26 rights granted by this title must conform to the following requirements:

27 (a) health care providers may communicate with other health care
28 providers regarding the terms and conditions to be negotiated with New
29 York Health;

30 (b) health care providers may communicate with health care providers'
31 representatives;

32 (c) a health care providers' representative is the only party author-
33 ized to negotiate with New York Health on behalf of the health care
34 providers as a group;

35 (d) a health care provider can be bound by the terms and conditions
36 negotiated by the health care providers' representatives; and

37 (e) in communicating or negotiating with the health care providers'
38 representative, New York Health is entitled to offer and provide differ-
39 ent terms and conditions to individual competing health care providers.

40 2. Nothing in this title shall affect or limit the right of a health
41 care provider or group of health care providers to collectively petition
42 a government entity for a change in a law, rule, or regulation.

43 3. Nothing in this title shall affect or limit collective action or
44 collective bargaining on the part of any health care provider with his
45 or her employer or any other lawful collective action or collective
46 bargaining.

47 § 4923. Requirements for health care providers' representative. Before
48 engaging in collective negotiations with New York Health on behalf of
49 health care providers, a health care providers' representative shall
50 file with the commissioner, in the manner prescribed by the commission-
51 er, information identifying the representative, the representative's
52 plan of operation, and the representative's procedures to ensure compli-
53 ance with this title.

54 § 4924. Mediation. 1. In the event the commissioner determines that an
55 impasse exists in the negotiations, the commissioner shall render
56 assistance as follows:

1 (a) to assist the parties to effect a voluntary resolution of the
2 negotiations, the commissioner shall appoint a mediator who is mutually
3 acceptable to both the health care providers' representative and the
4 representative of New York Health. If the mediator is successful in
5 resolving the impasse, then the health care providers' representative
6 shall proceed as set forth in this article;

7 (b) if an impasse continues, the commissioner shall appoint a fact-
8 finding board of not more than three members, who are mutually accepta-
9 ble to both the health care providers' representative and the represen-
10 tative of New York Health. The fact-finding board shall have, in
11 addition to the powers delegated to it by the board, the power to make
12 recommendations for the resolution of the dispute;

13 (c) the fact-finding board, acting by a majority of its members, shall
14 transmit its findings of fact and recommendations for resolution of the
15 dispute to the commissioner, and may thereafter assist the parties to
16 effect a voluntary resolution of the dispute. The fact-finding board
17 shall also share its findings of fact and recommendations with the
18 health care providers' representative and the representative of New York
19 Health. If within twenty days after the submission of the findings of
20 fact and recommendations, the impasse continues, the commissioner shall
21 order a resolution to the negotiations based upon the findings of fact
22 and recommendations submitted by the fact-finding board.

23 § 4925. Certain collective action prohibited. 1. This title is not
24 intended to authorize competing health care providers to act in concert
25 in response to a health care providers' representative's discussions or
26 negotiations with New York Health except as authorized by other law.

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 lawful scope
32 or terms of practice, license, registration, or certificate.

33 § 4926. Fees. Each person who acts as the representative of negotiat-
34 ing parties under this title shall pay to the department a fee to act as
35 a representative. The commissioner, by regulation, shall set fees in
36 amounts deemed reasonable and necessary to cover the costs incurred by
37 the department in administering this title.

38 § 4927. Confidentiality. All reports and other information required to
39 be reported to the department under this title shall not be subject to
40 disclosure under article six of the public officers law.

41 § 4928. Severability and construction. If any provision or application
42 of this title shall be held to be invalid, or to violate or be incon-
43 sistent with any applicable federal law or regulation, that shall not
44 affect other provisions or applications of this title which can be given
45 effect without that provision or application; and to that end, the
46 provisions and applications of this title are severable. The provisions
47 of this title shall be liberally construed to give effect to the
48 purposes thereof.

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

52 11. "State public health plan" means the medical assistance program
53 established by title eleven of article five of the social services law
54 (referred to in this article as "Medicaid"), the elderly pharmaceutical
55 insurance coverage program established by title three of article two of
56 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.

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

§ 89-j. 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", referred to in this section 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 taxes 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 or other arrangements agreed to by the United States secretary of health and human services or other appropriate federal officials for health care programs established under Medicare, any federally-matched public health program, or the affordable care act;

(c) the amounts paid by the department of health that are equivalent to those amounts that are paid on behalf of residents of this state under Medicare, any federally-matched public health program, or the affordable care act for health benefits which are equivalent to health benefits covered under New York Health;

(d) federal and state funds for purposes of the provision of services authorized under title XX of the federal social security act that would otherwise be covered under article fifty-one of the public health law; and

(e) state monies that would otherwise be appropriated to any governmental agency, office, program, instrumentality or institution which provides health services, for services and benefits covered under New York Health. Payments to the fund pursuant to this paragraph shall be in an amount equal to the money appropriated for such purposes in the fiscal year beginning immediately preceding the effective date of the New York Health act.

3. Monies in the fund shall only be used for purposes established under article fifty-one of the public health law.

§ 8. Temporary commission on implementation. 1. There is hereby established a temporary commission on implementation of the New York Health program, referred to in this section as the commission, consisting of fifteen members: five members, including the chair, shall be appointed by the governor; four members shall be appointed by the temporary president of the senate, one member shall be appointed by the senate minority leader; four members shall be appointed by the speaker of the assembly, and one member shall be appointed by the assembly minority leader. The commissioner of health, the superintendent of financial services, and the commissioner of taxation and finance, or their designees shall serve as non-voting ex-officio members of the commission.

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

1 3. The commission shall examine the laws and regulations of the state
2 and make such recommendations as are necessary to conform the laws and
3 regulations of the state and article 51 of the public health law estab-
4 lishing the New York Health program and other provisions of law relating
5 to the New York Health program, and to improve and implement the
6 program. The commission shall report its recommendations to the governor
7 and the legislature. The commission shall immediately begin development
8 of proposals consistent with the principles of article 51 of the public
9 health law for provision of health care services covered under the work-
10 ers' compensation law; and incorporation of retiree health benefits, as
11 described in paragraphs (a), (b) and (c) of subdivision 8 of section
12 5102 of the public health law. The commission shall provide its work
13 product and assistance to the board established pursuant to section 5102
14 of the public health law upon completion of the appointment of the
15 board.

16 § 9. Severability. If any provision or application of this act shall
17 be held to be invalid, or to violate or be inconsistent with any appli-
18 cable federal law or regulation, that shall not affect other provisions
19 or applications of this act which can be given effect without that
20 provision or application; and to that end, the provisions and applica-
21 tions of this act are severable.

22 § 10. This act shall take effect immediately.