STATE OF NEW YORK

10176

IN ASSEMBLY

May 10, 2024

Introduced by COMMITTEE ON RULES -- (at request of M. of A. Gonzalez-Rojas, Paulin) -- read once and referred to the Committee on Health

AN ACT to amend the public health law, in relation to data reporting required on the administration of managed long term care plans

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Subparagraph (ix) of paragraph (b) of subdivision 7 of section 4403-f of the public health law, as added by section 56-a of part D of chapter 56 of the laws of 2012 and as relettered by section 4 of part B of chapter 57 of the laws of 2018, is amended to read as follows:

(ix) (1) The commissioner shall report [~~biannually~~] **annually** on the implementation of this subdivision. The reports shall include, but not be limited to:

(A) satisfaction of enrollees with care coordination/case management; timeliness of care;

(B) service utilization data including changes in the level, hours, frequency, and types of services and providers;

(C) enrollment data, including auto-assignment rates by plan;

(D) quality data; and

(E) continuity of care for participants as they move to managed long term care, with respect to community based and nursing home populations, including pediatric nursing home populations, and medically fragile children being served by home care agencies affiliated with pediatric nursing homes and diagnostic and treatment centers primarily serving medically fragile children.

(2) **The following data shall be included in the report under this subdivision and shall be posted on the department's website in an interactive format. To the extent the data set forth in this subparagraph is not now reported by plans to the department, plans shall be required to report this data through a reporting mechanism that the department shall develop by October first, two thousand twenty-four:**

(A) Statewide and regional service utilization data for each plan, with the number and percentage of "member months" authorized for each

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

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range of hours per month as reported in cost reports filed under paragraph (a) of this subdivision, and using "member months" as defined in the cost reports, including all required exhibits. Data shall include the number of member months for whom each type of service was authorized, and the percentage of each plan's total member months for which members were authorized for each of the ranges of hours per month of each service. These numbers and percentages shall be reported separately for each of the following services: personal care, consumer directed personal care, private duty nursing and home health services, and shall be reported separately for each region of the state in which the plan operates and on a statewide basis;

(B) Data on "per member per month" expenditures by managed long term care plan, as reported in cost reports filed under paragraph (a) of this subdivision, including but not limited to, administrative costs, case management, personal care, consumer directed personal assistance programs, home health care, private duty nursing, adult day health care, social adult day, dental care, vision care, audiology, podiatry, medical supplies, durable medical equipment, personal emergency response system, home-delivered meals, the various therapy and rehab services - physical, occupational and speech therapy, and nursing facility services. The reports shall include, for each plan on a statewide and regional basis, a calculation of the total percentage of all service expenditures expended for home and community-based long term care services and the percentage for institutional long term care services, and the total number of member months in which members received home and community-based long term care services and the number of member months in which members received solely institutional services. The reports shall be in an interactive format that enables a comparison between plans on a statewide basis and for each region;

(C) Data on personal care and consumer directed personal assistance program contracting, including but not limited to, hours of care provided and expenses allocated by contracted entity;

(D) The total number of complaints, grievances, plan appeals, external appeals, and fair hearings for each plan, broken down by:

(I) the number and percentage of cases decided wholly in enrollee's favor, partially in enrollee's favor, wholly against the enrollee, and the number still pending;

(II) the type of service involved in the complaint or appeal; and

(III) the issue of the complaint or appeal, including denial of a new service, denial of an increase in a service, reduction of a service, termination of a service, lateness, lack of staffing, or other issue;

(E) Metrics to track timely access to authorized services, including but not limited to:

(I) the number of enrollees whose plans of care are unstaffed or not fully staffed for periods of time that the commissioner shall determine, from one day to more than sixty days, and the total number of member days per month for which plans of care are not fully staffed; and

(II) the wait time for personal care, consumer directed personal care under section three hundred-sixty-five-f of the social services law, or private duty nursing services to be initiated after authorization; and

(F) Metrics tracking rebalancing from institutional care to community-based care, including:

(I) for each plan, statewide and by region, the rate of admission of enrollees from the community to nursing facilities;

(II) of each plan's enrollees admitted to a nursing facility, the percentage successfully discharged to the community, meaning remaining

in the community for sixty days or more, and the percentage disenrolled from the plan pursuant to clause thirteen of subparagraph (v) of paragraph (b) of this subdivision and the percentage disenrolled because of death or for other reasons, categorized by length of nursing home stay;

(III) the rate of enrollment of new enrollees who, prior to enrollment, were in a nursing home, by length of nursing home stay;

(IV) the rate of re-enrollment of enrollees who had been disenrolled from the plan within the prior six months because of a long-term nursing home stay (under clause thirteen of subparagraph (v) of paragraph (b) of this subdivision).

(3) The commissioner shall publish the report on the department's website and provide notice to the temporary president of the senate, the speaker of the assembly, the chair of the senate standing committee on health, the chair of the assembly health committee and the Medicaid Managed Care Advisory Review Panel upon availability of the report. The initial report shall be provided by September first, two thousand twelve. The reports shall be made available by each February first, and September first thereafter. Such reports shall be formatted to allow comparisons between plans.

(4) The commissioner shall make the final audited versions of all past annual managed long term care cost reports available for download in full in CSV format on the department's website, and shall make the final audited versions of all future annual cost reports available for download within thirty days of completion of the final audited report.

§ 2. This act shall take effect immediately; provided, however, that the amendments to section 4403-f of the public health law, made by section one of this act shall not affect the repeal of such section and shall be deemed to repeal therewith; and provided, further, that the amendments to paragraph (b) of subdivision 7 of section 4403-f of the public health law made by section one of this act shall not affect the expiration of such paragraph and shall expire therewith.