# STATE OF NEW YORK

8470

2023-2024 Regular Sessions

# IN ASSEMBLY

December 29, 2023

Introduced by M. of A. PAULIN -- read once and referred to the Committee on Health

AN ACT to amend the public health law, the social services law, the elder law and the mental hygiene law, in relation to long term care options; and to repeal certain provisions of the public health law relating to managed long term care

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

Section 1. Legislative intent. The state, as part of an ambitious effort to move all Medicaid recipients to some form of managed care, moved those in need of home and community-based long term care services for over a one hundred twenty day period into managed long term care plans on a mandatory basis over ten years ago. The original intent of the MLTC program was that the managed long term care plans would develop into fully capitated plans over time. This has not happened.

Therefore, it is the intent of the legislature to repeal the partially capitated managed long term care program and instead, provide appropriate home and community-based long term care benefits under a fee-for-service arrangement. Fully capitated programs such as the PACE program shall continue to be an option. This transition shall not be implemented until the commissioner of health is satisfied that all necessary and appropriate transition planning has occurred, and federal approvals have been obtained.

§ 2. Section 4403-f of the public health law is REPEALED and a new section 4403-f is added to read as follows:

**§ 4403-f. Long term care options. 1. The following words or phrases, as used in this section, shall have the following meanings:**

**(a) "Program of all-inclusive care of the elderly" or "PACE" means a fully capitated federally recognized model of comprehensive care for persons fifty-five years of age or older that are eligible for medicaid and may also be eligible for Medicare, qualifying for nursing home**

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

LBD13640-07-3

levels of care who wish to remain in their community (see, Sections 1894 and 1934 to Title XVIII of the Social Security Act; 42 CFR 460), which are licensed to operate under article twenty-nine-ee of this chapter.

(b) "Medicaid advantage plus program" or "MAP" means a fully capitated state developed model of comprehensive care for persons eighteen years of age or older that are eligible for Medicaid and also eligible for medicare, qualifying for nursing home levels of care.

(c) "Care coordination entity" means an entity that has obtained approval from the commissioner based on guidelines established by the department to promote continuity of care and coordination of services for all enrollees. The entity may be organized as a health home specially certified by the commissioner to serve home and community-based services eligible recipients, but this shall not preclude other organizational structures as determined by the commissioner.

2. The commissioner shall submit the appropriate waivers, including but not limited to those authorized pursuant to sections eleven hundred fifteen and nineteen hundred fifteen of the federal social security act or successor provisions, and any other waivers necessary to require on or after April first, two thousand twenty-six, medical assistance recipients who are eighteen years of age or older and who require long term care services, as specified by the commissioner, for a continuous period of more than one hundred twenty days, to receive such services through an available fully integrated plan including a PACE or MAP plan, or through a fee-for-service based model with services coordinated by a care coordination entity. The commissioner shall establish guidelines on the establishment and operation of care coordination entities. Such guidelines shall address the payment methods that ensure provider accountability for cost effective quality outcomes. Copies of such waiver applications and amendments thereto shall be provided to the chairs of the senate finance committee, the assembly ways and means committee and the senate and assembly health committees before their submission to the federal government.

3. Persons that are determined eligible to receive long term care services through PACE or MAP, or through a fee-for-service based model with services coordinated by a care coordination entity established pursuant to subdivision two of this section shall have at least thirty days to select a PACE or MAP provider, or care coordination entity and shall be provided with information to make an informed choice. Where a participant has not selected such a provider or care coordination entity, the commissioner shall assign such participant to a care coordination entity taking into account consistency with any prior community-based direct care workers having recently served the recipient, quality performance criteria, capacity and geographic accessibility.

§ 3. Subdivision 2 of section 365-a of the social services law is amended by adding two new paragraphs (mm) and (nn) to read as follows:

(mm) The department shall promulgate regulations for all Medicaid enrollees receiving services through a fee-for-service model pursuant to section forty-four hundred three-f of the public health law that include the establishment and operation of care coordination entities to promote continuity of care and coordination of services to ensure that each enrollee has an ongoing source of care appropriate to their needs as required by 42 CFR § 438.208. The regulations shall include conflict-free case management protections to ensure that assessment and coordination of services are separate from the delivery of those services. In selecting providers of case management services, the department shall

**prioritize providers with proven experience serving populations receiving home and personal care services.**

**(nn) The department shall conduct an evaluation of the viability of utilizing care coordination entities operating pursuant to this section for assessments or reassessments required for determining an individual's needs for services that are controlled by the independent assessor established pursuant to subdivision ten of section three hundred sixty-five-a of this title.**

§ 4. Stakeholder engagement. 1. The commissioner of health shall convene an advisory group composed of stakeholder representatives which shall seek input from representatives of home and community-based long term care services providers, including representative associations, recipients, the department of health, local social services districts, and the direct care workforce, among others, to:

(a) further evaluate and promote the transition of persons in receipt of home and community-based long term care services into fee-for-service arrangements, where appropriate, and to develop guidelines for such care; and

(b) determine a process to transition providers, including but not limited to licensed home care services agencies, certified home health agencies, and fiscal intermediaries, to a fee-for-service reimbursement system.

2. In implementing the transition to a fee-for-service model the commissioner of health, in consultation with the advisory group, shall, to the extent practicable, consider and select programs and policies that seek to maximize continuity of care and minimize disruption to the provider labor workforce, and shall continue to support providers, licensed home care services agencies, and fiscal intermediaries that are based on a commitment to quality and value; provided that nothing in this subdivision shall supersede or invalidate any contracts or awards provided to fiscal intermediaries pursuant to subdivision 4-a of section 365-f of the social services law, provided that the provisions of subdivision 4-b of section 365-f of the social services law shall still apply, or contracts or awards provided to licensed home care services agencies pursuant to section 3605-c of the public health law.

3. The commissioner of health shall report biannually on the implementation of this section. The reports shall include, but not be limited to: (a) satisfaction of enrollees with care coordination/case management and timeliness of care; (b) service utilization data including changes in the level, hours, frequency, and types of services and providers; (c) enrollment data; (d) quality data; and (e) continuity of care for participants as they move out of managed long term care and into the fee-for-service model. 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 and the chair of the assembly health committee.

4. The commissioner of health shall seek input from representatives of home and community-based long term care services providers, recipients, and the Medicaid managed care advisory review panel, among others, to assist in the development of guidelines for the establishment and operation of care coordination entities pursuant to section 4403-f of the public health law. The guidelines shall be finalized and posted on the department of health's website no later than November first, two thousand twenty-five.

§ 5. Paragraph (o) of subdivision 2 of section 365-a of the social services law, as added by chapter 659 of the laws of 1997, is amended to read as follows:

(o) care and services furnished by a [~~managed long term care plan or approved managed long term care demonstration pursuant to the provisions of~~] **PACE or MAP plan as such terms are defined by** section forty-four hundred three-f of the public health law to eligible individuals [~~residing in the geographic area~~] served by such entity, when such services are furnished in accordance with an agreement with the department of health and meet the applicable requirements of federal law and regulation.

§ 6. Subparagraph (iii) of paragraph (e) of subdivision 2 of section 365-a of the social services law, as amended by section 36-a of part B of chapter 57 of the laws of 2015, is amended to read as follows:

(iii) the commissioner shall provide assistance to persons receiving services under this paragraph who are transitioning to receiving care from a [~~managed long term care plan certified pursuant to~~] **PACE or MAP plan as such terms are defined by** section forty-four hundred three-f of the public health law, consistent with subdivision thirty-one of section three hundred sixty-four-j of this title;

§ 7. Subdivision 10 of section 365-a of the social services law, as amended by section 1 of part QQ of chapter 57 of the laws of 2022, is amended to read as follows:

10. The department of health shall establish or procure the services of an independent assessor or assessors no later than October 1, 2022, in a manner and schedule as determined by the commissioner of health, to take over from local departments of social services[~~,~~] **and** Medicaid Managed Care providers, [~~and Medicaid managed long term care plans~~] **including a MAP plan, or a PACE plan if the PACE plan elects to utilize the independent assessor as such terms are defined by section forty-four hundred three-f of the public health law, the** performance of assessments and reassessments required for determining individuals' needs for personal care services, including as provided through the consumer directed personal assistance program, and other services or programs available pursuant to the state's medical assistance program as determined by such commissioner for the purpose of improving efficiency, quality, and reliability in assessment [~~and to determine individuals' eligibility for Medicaid managed long term care plans~~]. Notwithstanding the provisions of section one hundred sixty-three of the state finance law, or sections one hundred forty-two and one hundred forty-three of the economic development law, or any contrary provision of law, contracts may be entered or the commissioner may amend and extend the terms of a contract awarded prior to the effective date and entered into to conduct enrollment broker and conflict-free evaluation services for the Medicaid program, if such contract or contract amendment is for the purpose of procuring such assessment services from an independent assessor. Contracts entered into, amended, or extended pursuant to this subdivision shall not remain in force beyond September 30, 2025.

§ 8. Paragraph (d) of subdivision 1 and paragraph (h) of subdivision 3 of section 218 of the elder law, as amended by section 1 of chapter 259 of the laws of 2018, are amended to read as follows:

(d) "Long-term care facilities" shall mean residential health care facilities as defined in subdivision three of section twenty-eight hundred one of the public health law; adult care facilities as defined in subdivision twenty-one of section two of the social services law, including those adult homes and enriched housing programs licensed as

assisted living residences, pursuant to article forty-six-B of the public health law; or any facilities which hold themselves out or advertise themselves as providing assisted living services and which are required to be licensed or certified under the social services law or the public health law. Within the amounts appropriated therefor, "long-term care facilities" shall also mean [~~managed long-term care plans and approved managed long-term care or operating demonstrations~~] **a PACE or MAP plan** as **such terms are** defined in section forty-four hundred three-f of the public health law and the term "resident", "residents", "patient" and "patients" shall also include enrollees of such plans.

(h) Within the amounts appropriated therefor, the state long-term care ombudsman program shall include services specifically designed to serve persons enrolled in [~~managed long-term care plans or approved managed long-term care or operating demonstrations authorized under~~] **a PACE or MAP plan as such terms are defined by** section forty-four hundred three-f of the public health law, and shall also review and respond to complaints relating to marketing practices by such plans and demonstrations.

§ 9. Subdivisions (a), (c), (d), (f), the opening paragraph of subdivision (g) and subdivision (h) of section 13.40 of the mental hygiene law, subdivisions (a), (d), (f) and the opening paragraph of subdivision (g) as added by section 72-b of part A of chapter 56 of the laws of 2013, subdivision (c) as amended by section 17 of part Z of chapter 57 of the laws of 2018, and subdivision (h) as added by section 1 of part D of chapter 58 of the laws of 2014, are amended to read as follows:

(a) The commissioner and the commissioner of health shall jointly establish a people first waiver program for purposes of developing a care coordination model that integrates various long-term habilitation supports and/or health care. The people first waiver program shall include the use of developmental disability individual support and care coordination organizations, herein referred to as DISCOs, pursuant to section forty-four hundred three-g of the public health law, health maintenance organizations, herein referred to as HMOs, providing services under subdivision eight of section forty-four hundred three of the public health law, and long term care [~~managed~~] [~~plans, herein referred to as MLTCs~~] **options**, providing **or coordinating** services under [~~subdivisions twelve, thirteen and fourteen of~~] section forty-four hundred three-f of the public health law. Services shall be provided as described in section forty-four hundred three-g of the public health law, subdivision eight of section forty-four hundred three of the public health law, and [~~subdivisions twelve, thirteen and fourteen of~~] section forty-four hundred three-f of the public health law.

(c) No person with a developmental disability who is receiving or applying for medical assistance and who is receiving, or eligible to receive, services operated, funded, certified, authorized or approved by the office, shall be required to enroll in a DISCO, HMO or [~~MLTC~~] **long term care option** in order to receive such services until program features and reimbursement rates are approved by the commissioner and the commissioner of health, and until such commissioners determine that a sufficient number of plans that are authorized to coordinate care for individuals pursuant to this section or that are authorized to operate and to exclusively enroll persons with developmental disabilities pursuant to subdivision twenty-seven of section three hundred sixty-four-j of the social services law are operating in such person's county of residence to meet the needs of persons with developmental disabilities, and that such entities meet the standards of this section. No person shall

be required to enroll in a DISCO, HMO or [~~MLTC~~] long term care option in order to receive services operated, funded, certified, authorized or approved by the office until there are at least two entities operating under this section in such person's county of residence, unless federal approval is secured to require enrollment when there are less than two such entities operating in such county. Notwithstanding the foregoing or any other law to the contrary, any health care provider: (i) enrolled in the Medicaid program and (ii) rendering hospital services, as such term is defined in section twenty-eight hundred one of the public health law, to an individual with a developmental disability who is enrolled in a DISCO, HMO or [~~MLTC~~] long term care option, or a prepaid health services plan operating pursuant to section forty-four hundred three-a of the public health law, including, but not limited to, an individual who is enrolled in a plan authorized by section three hundred sixty-four-j [~~or~~] of the social services law, shall accept as full reimbursement the negotiated rate or, in the event that there is no negotiated rate, the rate of payment that the applicable government agency would otherwise pay for such rendered hospital services.

(d) DISCOs, HMOs and [~~MLTCs~~] long term care options operating under this section shall ensure, to the greatest extent practicable, that their assessment, services, and the grievance and appeals processes are culturally and linguistically competent.

(f) There shall be a joint advisory council chaired by the commissioner and the commissioner of health that shall be charged with advising both commissioners in regard to the oversight of DISCOs, HMOs providing services under subdivision eight of section forty-four hundred three of the public health law, and [~~MLTCs~~] long term care options providing services under [~~subdivisions twelve, thirteen and fourteen of~~] section forty-four hundred three-f of the public health law. The joint advisory council may be comprised of the members of existing advisory councils or similar entities serving the office, provided that it shall be comprised of twelve members, including individuals with developmental disabilities, family members of, advocates for, and providers of services to people with developmental disabilities. Three members of the joint advisory council shall also be members of the special advisory review panel on medicaid managed care established under section three hundred sixty-four-jj of the social services law. The joint advisory council shall review all managed care options provided to individuals with developmental disabilities, including: the adequacy of habilitation services; the record of compliance with person-centered planning, person-centered services and community integration; the adequacy of rates paid to providers in accordance with the provisions of [~~paragraph one of subdivision four of~~] section forty-four hundred three of the public health law, paragraph [~~a-two~~] (a-2) of subdivision eight of section forty-four hundred three of the public health law or [~~paragraph a-two of subdivision twelve of~~] section forty-four hundred three-f of the public health law; and quality of life, health, safety and community integration of individuals with developmental disabilities enrolled in managed care. The commissioner and commissioner of the office for people with developmental disabilities or their designees shall attend all meetings of the joint advisory council. The joint advisory council shall report its findings, recommendations, and any proposed amendments to pertinent sections of the law to the commissioner and the commissioner of health, the senate majority leader and speaker of the assembly. The joint advisory council shall have access to any and all information that may be

lawfully disclosed to it and that is necessary to perform its functions under this section.

Notwithstanding any inconsistent provision of sections one hundred twelve and one hundred sixty-three of the state finance law, or section one hundred forty-two of the economic development law, or any other law to the contrary, the commissioner and the commissioner of health are authorized to enter into a contract or contracts under section forty-four hundred three-g of the public health law, subdivision eight of section forty-four hundred three of the public health law, and [~~subdivision twelve of~~] section forty-four hundred three-f of the public health law, provided, however, that:

(h) Consistent with and subject to the terms of federal approval, the commissioner shall establish the managed care for persons with developmental disabilities advocacy program, hereinafter referred to as the advocacy program. The activities of the advocacy program shall be coordinated with the independent Medicaid managed care ombuds services provided to persons with disabilities enrolling in Medicaid managed care. The advocacy program shall advise individuals of applicable rights and responsibilities, provide information and assistance to address the needs of individuals with disabilities, and pursue legal, administrative and other appropriate remedies or approaches to ensure the protection of and advocacy for the rights of the enrollees. The advocacy program shall provide support to eligible individuals with developmental disabilities enrolling in developmental disability individual support and care coordination organizations pursuant to section forty-four hundred three-g of the public health law, health maintenance organizations providing services pursuant to subdivision eight of section forty-four hundred three of the public health law, [~~managed long term care plans~~] long term care options providing services under [~~subdivisions twelve, thirteen and fourteen of~~] section forty-four hundred three-f of the public health law, and fully integrated dual advantage plans providing services under subdivision twenty-seven of section three hundred sixty-four-j of the social services law. The commissioner shall select an independent organization or organizations to provide advocacy services under this subdivision.

§ 10. Paragraph (c) of subdivision 6 of section 2801-e of the public health law, as amended by chapter 257 of the laws of 2005, is amended to read as follows:

(c) The commissioner may, as necessary, waive existing methodologies for determining public need under this article, article thirty-six of this chapter and article seven of the social services law[~~, as well as enrollment limitations under section forty-four hundred three-f of this chapter,~~] to accommodate permanent conversions of beds to other programs or services on the basis that any such increases in capacity are linked to commensurate reductions in the number of residential health care facility beds.

§ 11. The opening paragraph of paragraph (ccc) of subdivision 1 of section 2807-v of the public health law, as amended by section 12 of part C of chapter 57 of the laws of 2023, is amended to read as follows:

Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for the deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of increases in the rates for certified home health agencies, long term home health care programs, AIDS home care programs, hospice programs and

[~~managed~~] long term care [~~plans and approved managed long term care operating demonstrations as defined in~~] **options in** section forty-four hundred three-f of this chapter for recruitment and retention of health care workers pursuant to subdivisions nine and ten of section thirty-six hundred fourteen of this chapter from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

§ 12. Section 2807-x of the public health law is REPEALED.

§ 13. Subdivision 8 of section 3605 of the public health law, as amended by section 49 of part D of chapter 56 of the laws of 2012, is amended to read as follows:

8. Agencies licensed pursuant to this section but not certified pursuant to section [~~three thousand six hundred eight~~] **thirty-six hundred eight** of this article, shall not be qualified to participate as a home health agency under the provisions of title XVIII or XIX of the federal Social Security Act provided, however, an agency which has a contract with a state agency or its locally designated office or, as specified by the commissioner, with a managed care organization participating in the managed care program established pursuant to section three hundred sixty-four-j of the social services law or with a [~~managed long term care plan established pursuant to~~] **PACE or MAP plan as such terms are defined by** section forty-four hundred three-f of this chapter, may receive reimbursement under title XIX of the federal Social Security Act.

§ 14. The opening paragraph of subdivision 9 of section 3614 of the public health law, as amended by section 56 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

Notwithstanding any law to the contrary, the commissioner shall, subject to the availability of federal financial participation, adjust medical assistance rates of payment for certified home health agencies for such services provided to children under eighteen years of age and for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the department, long term home health care programs, AIDS home care programs established pursuant to this article, hospice programs established under article forty of this chapter and for [~~managed~~] long term care [~~plans and approved managed long term care operating demonstrations as defined in~~] **options under** section forty-four hundred three-f of this chapter. Such adjustments shall be for purposes of improving recruitment, training and retention of home health aides or other personnel with direct patient care responsibility in the following aggregate amounts for the following periods:

§ 15. Paragraph (a) of subdivision 10 of section 3614 of the public health law, as amended by section 57 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

(a) Such adjustments to rates of payments shall be allocated proportionally based on each certified home health agency, long term home health care program, AIDS home care and hospice program's home health aide or other direct care services total annual hours of service provided to medicaid patients, as reported in each such agency's most recently available cost report as submitted to the department or for the purpose of the [~~managed~~] long term care [~~program~~] **option** a suitable proxy developed by the department in consultation with the interested parties. Payments made pursuant to this section shall not be subject to subsequent adjustment or reconciliation; provided that such adjustments

to rates of payments to certified home health agencies shall only be for that portion of services provided to children under eighteen years of age and for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the department.

§ 16. Paragraph (b) of subdivision 2 of section 4409 of the public health law, as added by section 5 of part NN of chapter 57 of the laws of 2023, is amended to read as follows:

(b) The department is authorized to address to any health maintenance organization, and [~~managed long term care plan with a certificate of authority pursuant to~~] a PACE or MAP plan as such terms are defined by section forty-four hundred three-f of this article, or officers thereof, any inquiry in relation to its contracts with providers and other entities providing covered services to the health maintenance organization's, or [~~managed long term care plan's~~] PACE or MAP plans' enrollees, including but not limited to the rates of payment and payment terms and conditions therein. Every entity or person so addressed shall reply in writing to such inquiry promptly and truthfully, and such reply shall be, if required by the department, signed by such individual, or by such officer or officers of a corporation, as the department shall designate, and affirmed by them as true under penalty of perjury. Failure to comply with the requirements of this section shall be subject to civil penalties under section twelve of this chapter. Each day after the deadline established by the department for reply until such time that the provider submits a good faith response shall be considered a separate and subsequent violation. In accordance with the process outlined in this paragraph, employers shall provide any documents or materials in the employer's possession, custody, or control that are requested by the department as needed to support or verify the employer's reply.

§ 17. Subparagraph (i) of paragraph (e) of subdivision 3 of section 364-j of the social services law, as amended by section 38 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

(i) an individual dually eligible for medical assistance and benefits under the federal Medicare program; provided, however, nothing herein shall: (a) require an individual enrolled in a [~~managed~~] long term care [~~plan~~] option, pursuant to section forty-four hundred three-f of the public health law, to disenroll from such program; or (b) make enrollment in a Medicare managed care plan a condition of the individual's participation in the managed care program pursuant to this section, or affect the individual's entitlement to payment of applicable Medicare managed care or [~~fee for service~~] fee-for-service coinsurance and deductibles by the individual's managed care provider.

§ 18. Paragraphs (b) and (c) of subdivision 27 of section 364-j of the social services law, as added by section 72 of part A of chapter 56 of the laws of 2013, are amended to read as follows:

(b) The FIDA program shall provide targeted populations of [~~medicare/medicaid~~] Medicare/Medicaid dually eligible persons with comprehensive health services that include the full range of [~~medicare~~] Medicare and [~~medicaid~~] Medicaid covered services, including but not limited to primary and acute care, prescription drugs, behavioral health services, care coordination services, and long-term supports and services, as well as other services, through managed care providers, as defined in subdivision one of this section[~~, including managed long term care plans, certified pursuant to section forty-four hundred three-f of the public health law~~].

(c) Under the FIDA program established pursuant to this subdivision, up to three managed [~~long term~~] care plans may be authorized to exclusively enroll individuals with developmental disabilities, as such term is defined in section 1.03 of the mental hygiene law. The commissioner of health may waive any of the department's regulations as such commissioner, in consultation with the commissioner of the office for people with developmental disabilities, deems necessary to allow such managed [~~long term~~] care plans to provide or arrange for service for individuals with developmental disabilities that are adequate and appropriate to meet the needs of such individuals and that will ensure their health and safety. The commissioner of the office for people with developmental disabilities may waive any of the office for people with developmental disabilities' regulations as such commissioner, in consultation with the commissioner of health, deems necessary to allow such managed [~~long term~~] care plans to provide or arrange for services for individuals with developmental disabilities that are adequate and appropriate to meet the needs of such individuals and that will ensure their health and safety.

§ 19. Subdivision 31 of section 364-j of the social services law, as added by section 36-b of part B of chapter 57 of the laws of 2015, is amended to read as follows:

31. [~~(a)~~] The commissioner shall require managed care providers under this section, [~~managed long-term care plans~~] **a PACE or MAP plan as such terms are defined** under section forty-four hundred three-f **of** the public health law and other appropriate long-term service programs to adopt expedited procedures for approving personal care services for a medical assistance recipient who requires immediate personal care or consumer directed personal assistance services pursuant to paragraph (e) of subdivision two of section three hundred sixty-five-a of this title or section three hundred sixty-five-f of this title, respectively, or other long-term care, and provide such care or services as appropriate, pending approval by such provider or program.

§ 20. Paragraphs (a) and (c) of subdivision 32 of section 364-j of the social services law, as amended by section 1 of part KKK of chapter 56 of the laws of 2020, are amended to read as follows:

(a) The commissioner, or for the purposes of subparagraph (iv) of paragraph (c) of this subdivision, the Medicaid inspector general in consultation with the commissioner, may, in his or her discretion, apply penalties to managed care organizations subject to this section and article forty-four of the public health law, including [~~managed long term care plans~~] **a PACE or MAP plan as such terms are defined by section forty-four hundred three-f of the public health law**, for untimely or inaccurate submission of encounter data; provided however, no penalty shall be assessed if the managed care organization **or a PACE or MAP plan** submits, in good faith, timely and accurate data and a material amount of such data is not successfully received by the department as a result of department system failures or technical issues that are beyond the control of the managed care organization.

(c) (i) Penalties assessed pursuant to this subdivision against a managed care organization other than a [~~managed long term care plan certified pursuant to~~] **PACE or MAP plan as such terms are defined by** section forty-four hundred three-f of the public health law shall be as follows:

(A) for encounter data submitted or resubmitted past the deadlines set forth in the model contract, the Medicaid capitated premiums shall be reduced by one-third percent; [~~and~~]

(B) for incomplete or inaccurate encounter data, evaluated at a category of service level, that fails to conform to department developed benchmarks for completeness and accuracy, the Medicaid capitated premiums shall be reduced by one and one-third percent; and

(C) for submitted data that results in a rejection rate in excess of ten percent of department developed volume benchmarks, the Medicaid capitated premiums shall be reduced by one-third percent.

(ii) Penalties assessed pursuant to this [~~subdivisions~~] **subdivision** against a [~~managed~~] long term care [~~plan~~] **option** certified pursuant to section forty-four hundred three-f of the public health law shall be as follows:

(A) for encounter data submitted or resubmitted past the deadlines set forth in the model contract, the Medicaid capitated premiums shall be reduced by one-quarter percent;

(B) for incomplete or inaccurate encounter data, evaluated at a category of service level, that fails to conform to department developed benchmarks for completeness and accuracy, the Medicaid capitated premiums shall be reduced by one percent; and

(C) for submitted data that results in a rejection rate in excess of ten percent of department developed volume benchmarks, the Medicaid capitated premiums shall be reduced by one-quarter percent.

(iii) For incomplete or inaccurate encounter data, identified in the course of an audit, investigation or review by the Medicaid inspector general, the Medicaid capitated premiums shall be reduced by an additional one percent.

§ 21. Paragraph (x) of subdivision (b) of section 364-jj of the social services law, as amended by section 39 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

(x) in accordance with the recommendations of the joint advisory council established pursuant to section 13.40 of the mental hygiene law, advise the commissioners of health and developmental disabilities with respect to the oversight of DISCOs and of health maintenance organizations and [~~managed~~] long term care [~~plans~~] **options** providing services authorized, funded, approved or certified by the office for people with developmental disabilities, and review all managed care options provided to persons with developmental disabilities, including: the adequacy of support for habilitation services; the record of compliance with requirements for person-centered planning, person-centered services and community integration; the adequacy of rates paid to providers in accordance with the provisions of [~~paragraph 1 of~~] subdivision four of section forty-four hundred three of the public health law, paragraph (a-2) of subdivision eight of section forty-four hundred three of the public health law or [~~paragraph (a-2) of subdivision twelve of~~] section forty-four hundred three-f of the public health law; and the quality of life, health, safety and community integration of persons with developmental disabilities enrolled in managed care; and

§ 22. Subdivision 6 of section 365-f of the social services law, as added by section 50 of part D of chapter 56 of the laws of 2012, is amended to read as follows:

6. Notwithstanding any inconsistent provision of this section or any other contrary provision of law, managed care programs established pursuant to section three hundred sixty-four-j of this title and [~~managed~~] long term care [~~plans~~] **options** and other care coordination models established pursuant to section [~~four thousand four~~] **forty-four** hundred three-f of the public health law shall offer consumer directed personal assistance programs to enrollees.

§ 23. Paragraph (a) of subdivision 4 of section 365-h of the social services law, as amended by section 2 of part LL of chapter 56 of the laws of 2020, is amended to read as follows:

(a) The commissioner of health is authorized to assume responsibility from a local social services official for the provision and reimbursement of transportation costs under this section. If the commissioner elects to assume such responsibility, the commissioner shall notify the local social services official in writing as to the election, the date upon which the election shall be effective and such information as to transition of responsibilities as the commissioner deems prudent. The commissioner is authorized to contract with a transportation manager or managers to manage transportation services in any local social services district, other than transportation services provided or arranged for enrollees of [~~managed long term care plans issued certificates of authority under~~] a PACE or MAP plan as defined by section forty-four hundred three-f of the public health law. Any transportation manager or managers selected by the commissioner to manage transportation services shall have proven experience in coordinating transportation services in a geographic and demographic area similar to the area in New York state within which the contractor would manage the provision of services under this section. Such a contract or contracts may include responsibility for: review, approval and processing of transportation orders; management of the appropriate level of transportation based on documented patient medical need; and development of new technologies leading to efficient transportation services. If the commissioner elects to assume such responsibility from a local social services district, the commissioner shall examine and, if appropriate, adopt quality assurance measures that may include, but are not limited to, global positioning tracking system reporting requirements and service verification mechanisms. Any and all reimbursement rates developed by transportation managers under this subdivision shall be subject to the review and approval of the commissioner.

§ 24. Subparagraph (vi) of paragraph (b) of subdivision 4 of section 365-h of the social services law, as added by section 2 of part LL of chapter 56 of the laws of 2020, is amended to read as follows:

(vi) Responsibility for transportation services provided or arranged for enrollees of [~~managed~~] long term care [~~plans issued certificates of authority~~] options under section forty-four hundred three-f of the public health law, not including a program designated as a Program of All-Inclusive Care for the Elderly (PACE) as authorized by Federal Public law 1053-33, subtitle I of title IV of the Balanced Budget Act of 1997, and, at the commissioner's discretion, other plans that integrate benefits for dually eligible Medicare and Medicaid beneficiaries based on a demonstration by the plan that inclusion of transportation within the benefit package will result in cost efficiencies and quality improvement, shall be transferred to a transportation management broker that has a contract with the commissioner in accordance with this paragraph. Providers of adult day health care may elect to, but shall not be required to, use the services of the transportation management broker.

§ 25. Subdivision 14 of section 366 of the social services law, as amended by section 1 of part NN of chapter 57 of the laws of 2021, is amended to read as follows:

14. The commissioner of health may make any available amendments to the state plan for medical assistance submitted pursuant to section three hundred sixty-three-a of this title, or, if an amendment is not possible, develop and submit an application for any waiver or approval

under the federal social security act that may be necessary to disregard or exempt an amount of income, for the purpose of assisting with housing costs, for individuals receiving coverage of nursing facility services under this title, other than short-term rehabilitation services, and for individuals in receipt of medical assistance while in an adult home, as defined in subdivision twenty-five of section two of this chapter, who: are (i) discharged to the community; and (ii) if eligible, enrolled or required to enroll and have initiated the process of enrolling in a [~~plan certified~~] long term care option pursuant to section forty-four hundred three-f of the public health law; and (iii) do not meet the criteria to be considered an "institutionalized spouse" for purposes of section three hundred sixty-six-c of this title.

§ 26. This act shall take effect immediately; provided, however, that:

(i) sections two, five, six, seven, eight, nine, ten, eleven, twelve, thirteen, fourteen, fifteen, sixteen, seventeen, eighteen, nineteen, twenty, twenty-one, twenty-two, twenty-three, twenty-four and twenty-five of this act shall take effect April 1, 2026.

(ii) the amendments to paragraph (o) of subdivision 2 of section 365-a of the social services law made by section five of this act shall not affect the expiration and/or repeal of such paragraph and shall be deemed to expire therewith;

(iii) the amendments to paragraph (h) of subdivision 3 of section 218 of the elder law made by section eight of this act shall be subject to the repeal of such paragraph and shall expire and be deemed repealed therewith;

(iv) the amendments to subparagraph (i) of paragraph (e) of subdivision 3, paragraphs (b) and (c) of subdivision 27, subdivision 31 and paragraphs (a) and (c) of subdivision 32 of section 364-j of the social services law made by sections seventeen, eighteen, nineteen and twenty of this act shall be subject to the repeal of such section and shall expire and be deemed repealed therewith;

(v) the amendments to paragraph (x) of subdivision (b) of section 364-jj of the social services law made by section twenty-one of this act shall be subject to the expiration of such section and shall expire and be deemed repealed therewith; and

(vi) the amendments to section 365-h of the social services law made by sections twenty-three and twenty-four of this act shall be subject to the expiration of such section and shall expire and be deemed repealed therewith.

Effective immediately, the commissioner of health shall promulgate any rules and regulations and take steps, including requiring the submission of reports or surveys, submission and receipt of state plans, and necessary federal waivers, as may be necessary for the timely implementation of this act on such effective date.