*** § 4403-f. Managed long term care plans.** 1. Definitions. As used in this section:

(a) "Managed long term care plan" means an entity that has received a certificate of authority pursuant to this section to provide, or arrange for, health and long term care services, on a capitated basis in accordance with this section, for a population, age eighteen and over, which the plan is authorized to enroll.

(b) "Eligible applicant" means an entity controlled or wholly owned by one or more of the following: a hospital as defined in subdivision one of section twenty-eight hundred one of this chapter; a home care agency licensed or certified pursuant to article thirty-six of this chapter; an entity that has received a certificate of authority pursuant to sections forty-four hundred three, forty-four hundred three-a or forty-four hundred eight-a of this article (as added by chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six), or a health maintenance organization authorized under article forty-three of the insurance law; or a not-for-profit organization which has a history of providing or coordinating health care services and long term care services to the elderly and disabled.

(c) "Operating demonstration" means the following entities: the chronic care management demonstration programs authorized by chapter five hundred thirty of the laws of nineteen hundred eighty-eight, chapter five hundred ninety-seven of the laws of nineteen hundred ninety-four and chapter eighty-one of the laws of nineteen hundred ninety-five as amended.

(d) "Health and long term care services" means services including, but not limited to home and community-based and institution-based long term care and ancillary services (that shall include medical supplies and nutritional supplements) that are necessary to meet the needs of persons whom the plan is authorized to enroll. The managed long term care plan may also cover primary care, acute care and behavioral health services if so authorized.

2. Certificate of authority; form. An eligible applicant shall submit an application for a certificate of authority to operate a managed long term care plan upon forms prescribed by the commissioner. Such eligible applicant shall submit information and documentation to the commissioner

which shall include, but not be limited to:

(a) a description of the service area proposed to be served by the plan with projections of enrollment that will result in a fiscally sound plan;

(b) a description of the proposed target population and the marketing plan;

(c) adequate documentation of the appropriate licenses, certifications or approvals to provide care as planned, including contracts with such providers as may be necessary to provide the full complement of services required to be provided under this section.

3. Certificate of authority; approval. The commissioner shall not approve an application for a certificate of authority unless the applicant demonstrates to the commissioner's satisfaction:

(a) that it will have in place acceptable quality-assurance mechanisms, grievance procedures, mechanisms to protect the rights of enrollees and case management services to ensure continuity, quality, appropriateness and coordination of care;

(b) that it will include an enrollment process which shall ensure that enrollment in the plan is informed. The application shall describe the disenrollment process, which shall provide that an otherwise eligible enrollee shall not be involuntarily disenrolled on the basis of health status;

(c) satisfactory evidence of the character and competence of the proposed operators and reasonable assurance that the applicant will provide high quality services to an enrolled population;

(d) sufficient management systems capacity to meet the requirements of this section and the ability to efficiently process payment for covered services;

(e) readiness and capability to maximize reimbursement of and coordinate services reimbursed pursuant to title XVIII of the federal social security act and all other applicable benefits, with such benefit coordination including, but not limited to, measures to support sound clinical decisions, reduce administrative complexity, coordinate access to services, maximize benefits available pursuant to such title and ensure that necessary care is provided;

(f) readiness and capability to arrange and manage covered services

and coordinate non-covered services which could include primary, specialty, and acute care services reimbursed pursuant to title XIX of the federal social security act;

(g) willingness and capability of taking, or cooperating in, all steps necessary to secure and integrate any potential sources of funding for services provided by the managed long term care plan, including, but not limited to, funding available under titles XVI, XVIII, XIX and XX of the federal social security act, the federal older Americans act of nineteen hundred sixty-five, as amended, or any successor provisions subject to approval of the director of the state office for aging, and through financing options such as those authorized pursuant to section three hundred sixty-seven-f of the social services law;

(h) that the contractual arrangements for providers of health and long term care services in the benefit package are sufficient to ensure the availability and accessibility of such services to the proposed enrolled population consistent with guidelines established by the commissioner; with respect to individuals in receipt of such services prior to enrollment, such guidelines shall require the managed long term care plan to contract with agencies currently providing such services, in order to promote continuity of care. In addition, such guidelines shall require managed long term care plans to offer and cover consumer directed personal assistance services for eligible individuals who elect such services pursuant to section three hundred sixty-five-f of the social services law; and

(i) that the applicant is financially responsible and may be expected to meet its obligations to its enrolled members.

4. Solvency. (a) The commissioner shall be responsible for evaluating, approving and regulating all matters relating to fiscal solvency, including reserves, surplus and provider contracts. The commissioner may promulgate regulations to implement this section. The commissioner, in the administration of this subdivision:

(i) shall be guided by the standards which govern the fiscal solvency of a health maintenance organization, provided, however, that the commissioner shall recognize the specific delivery components, operational capacity and financial capability of the eligible applicant for a certificate of authority;

(ii) shall not apply financial solvency standards that exceed those required for a health maintenance organization; and

(iii) shall establish reasonable capitalization and contingent reserve requirements.

(b) Standards established pursuant to this subdivision shall be adequate to protect the interests of enrollees in managed long term care plans. The commissioner shall be satisfied that the eligible applicant is financially sound, and has made adequate provisions to pay for services.

4-a. Role of the superintendent of financial services. (a) The superintendent of financial services shall determine and approve premiums in accordance with the insurance law whenever any population of enrollees not eligible under title XIX of the federal social security act is to be covered. The determination and approval of the superintendent of financial services shall relate to premiums charged to such enrollees not eligible under title XIX of the federal social security act.

(b) The superintendent of financial services shall evaluate and approve any enrollee contracts whenever such enrollee contracts are to cover any population of enrollees not eligible under title XIX of the federal social security act.

5. Applicability of other laws. A managed long term care plan shall be subject to the provisions of the insurance law and regulations applicable to health maintenance organizations, this article and regulations promulgated pursuant thereto. To the extent that the provisions of this section are inconsistent with the provisions of this chapter or the provisions of the insurance law, the provisions of this section shall prevail.

6. Approval authority. (a) An applicant shall be issued a certificate of authority as a managed long term care plan upon a determination by the commissioner that the applicant complies with the operating requirements for a managed long term care plan under this section. The commissioner shall issue no more than seventy-five certificates of authority to managed long term care plans pursuant to this section.

(a-1) Nothing in this section shall be construed as requiring the department to contract with or to contract for a particular line of business with an entity certified under this section for the provision of services available under title eleven of article five of the social services law. A managed long term care plan that has been issued a certificate of authority, or an applicant for a certificate of authority as a managed long term care plan that has in any of the three calendar years immediately preceding the application, met any of the following criteria shall not be eligible for a contract for the provision of services available under title eleven of article five of the social services law: (i) classified as a poor performer, or substantially similar terminology, by the centers for medicare and medicaid services; or (ii) an excessive volume of penalties, statements of findings, statements of deficiency, intermediate sanctions or enforcement actions, regardless of whether the applicant has addressed such issues in a timely manner.

(b) An operating demonstration shall be issued a certificate of authority as a managed long term care plan upon a determination by the commissioner that such demonstration complies with the operating requirements for a managed long term care plan under this section. Nothing in this section shall be construed to affect the continued legal authority of an operating demonstration to operate its previously approved program.

(c) For the period beginning April first, two thousand twelve and ending March thirty-first, two thousand fifteen, the majority leader of the senate and the speaker of the assembly may each recommend to the commissioner, in writing, up to four eligible applicants to convert to be approved managed long term care plans. An applicant shall only be approved and issued a certificate of authority if the commissioner determines that the applicant meets the requirements of subdivision three of this section. The majority leader of the senate or the speaker of the assembly may assign their authority to recommend one or more applicants under this section to the commissioner.

(d) (i) Effective April first, two thousand twenty, and expiring March thirty-first, two thousand twenty-seven, the commissioner shall place a moratorium on the processing and approval of applications seeking a certificate of authority as a managed long term care plan pursuant to

this section, including applications seeking authorization to expand an existing managed long term care plan's approved service area or scope of eligible enrollee populations. Such moratorium shall not apply to:

(A) applications submitted to the department prior to January first, two thousand twenty;

(B) applications seeking approval to transfer ownership or control of an existing managed long term care plan;

(C) applications demonstrating to the commissioner's satisfaction that submission of the application for consideration would be appropriate to address a serious concern with care delivery, such as a lack of adequate access to managed long term care plans in a geographic area or a lack of adequate and appropriate care, language and cultural competence, or special needs services; and

(D) applications seeking to operate under the PACE (Program of All-Inclusive Care for the Elderly) model as authorized by federal public law 105-33, subtitle I of title IV of the Balanced Budget Act of 1997, or to serve individuals dually eligible for services and benefits under titles XVIII and XIX of the federal social security act in conjunction with an affiliated Medicare Dual Eligible Special Needs Plan, based on the need for such plans and the experience of applicants in serving dually eligible individuals as determined by the commissioner in their discretion.

(ii) For the duration of the moratorium, the commissioner shall assess the public need for managed long term care plans that are not integrated with an affiliated Medicare plan, the ability of such plans to provide high quality and cost effective care for their membership, and based on such assessment develop a process and conduct an orderly wind-down and elimination of such plans, which shall coincide with the expiration of the moratorium unless the commissioner determines that a longer wind-down period is needed.

(e) For the duration of the moratorium under paragraph (d) of this subdivision, the commissioner shall establish, and enforce by means of a premium withholding equal to three percent of the base rate, an annual cap on total enrollment (enrollment cap) for each managed long term care plan, subject to subparagraphs (ii) and (iii) of this paragraph, based on a percentage of each plan's reported enrollment as of October first, two thousand twenty.

(i) The specific percentage of each plan's enrollment cap shall be established by the commissioner based on: (A) the ability of individuals eligible for such plans to access health and long term care services, (B) plan quality of care scores, (C) historical plan disenrollment, (D) the projected growth of individuals eligible for such plans in different regions of the state, (E) historical plan enrollment of patients with varying levels of need and acuity, and (F) other factors in the commissioner's discretion to ensure compliance with federal requirements, appropriate access to plan services, and choice by eligible individuals.

(ii) In the event that a plan exceeds its annual enrollment cap, the commissioner is authorized under this paragraph to retain all or a portion of the premium withheld based on the amount over which a plan exceeds its enrollment cap. Penalties assessed pursuant to this subdivision shall be determined by regulation.

(iii) The commissioner may not establish an annual cap on total enrollment under this paragraph for plans' lines of business operating under the PACE (Program of All-Inclusive Care for the Elderly) model as authorized by federal public law 105-33, subtitle I of title IV of the Balanced Budget Act of 1997, or that serve individuals dually eligible for services and benefits under titles XVIII and XIX of the federal social security act in conjunction with an affiliated Medicare Dual Eligible Special Needs Plan.

(f) In implementing the provisions of paragraphs (d) and (e) of this subdivision, the commissioner shall, to the extent practicable, consider and select methodologies that seek to maximize continuity of care and minimize disruption to the provider labor workforce, and shall, to the extent practicable and consistent with the ratios set forth herein, continue to support contracts between managed long term care plans and licensed home care services agencies that are based on a commitment to quality and value.

6-a. Performance standards. (a) On or before January first, two thousand twenty-four, each managed long term care plan that has been issued a certificate of authority pursuant to this section shall have an active Medicare Dual Eligible Special Needs Plan in operation whose H-contract either has a current quality star rating from the Centers for

Medicare and Medicaid Services of three stars or higher, or has not been issued a quality star rating from the Centers for Medicare and Medicaid Services. In addition, the managed long term care plan shall sufficiently demonstrate success in the following performance categories:

(i) in addition to meeting the requirements of paragraph (j) of subdivision seven of this section, in order to ensure network adequacy a commitment to contracting with an adequate number of licensed home care service agencies needed to provide necessary personal care services to the greatest practicable number of enrollees, and with an adequate number of fiscal intermediaries needed to provide necessary consumer directed personal assistance services to the greatest practicable number of enrollees in accordance with section three hundred sixty-five-f of the social services law;

(ii) readiness to timely implement and adhere to maximum wait time criteria for key categories of service in accordance with laws, rules and regulations of the department or the Centers for Medicare and Medicaid Services;

(iii) commitment to quality improvement;

(iv) accessibility and geographic distribution of network providers, taking into account the needs of persons with disabilities and the differences between rural, suburban, and urban settings;

(v) demonstrated cultural and language competencies specific to the population of participants;

(vi) ability to serve enrollees across the continuum of care, as demonstrated by the type and number of products the managed long term care operates or has applied to operate, including integrated care for participants who are dually eligible for Medicaid and Medicare, and those operated under title one-A of article twenty-five of this chapter and section three hundred sixty-nine-gg of the social services law; and

(vii) value based care readiness and experience.

(b) The commissioner shall require any managed long term care plan with a Medicare Dual Eligible Special Needs Plan in operation that at any time has a current quality star rating from the Centers for Medicare and Medicaid Services of less than three stars to establish and implement a performance improvement plan acceptable to the commissioner, and which shall be consistent with the standards of the Medicare

Advantage Quality Rating System.

(c) The commissioner shall have the authority to promulgate regulations to effectuate the provisions of this subdivision.

(d) The provisions of this subdivision shall not apply for managed long term care plans operating under a certificate of authority pursuant to subdivision twelve, as added by section seventy-six of part A of chapter fifty-six of the laws of two thousand thirteen, or subdivision thirteen of this section, or to the program of all-inclusive care for the elderly under article twenty-nine-EE of this chapter.

7. Program oversight and administration. (a)(i) The commissioner shall promulgate regulations to implement this section and to ensure the quality, appropriateness and cost-effectiveness of the services provided by managed long term care plans. The commissioner may waive rules and regulations of the department, including but not limited to, those pertaining to duplicative requirements concerning record keeping, boards of directors, staffing and reporting, when such waiver will promote the efficient delivery of appropriate, quality, cost-effective services and when the health, safety and general welfare of enrollees will not be impaired as a result of such waiver. In order to achieve managed long term care plan system efficiencies and coordination and to promote the objectives of high quality, integrated and cost effective care, the commissioner may establish a single coordinated surveillance process, allow for a comprehensive quality improvement and review process to meet component quality requirements, and require a uniform cost report. The commissioner shall require managed long term care plans to utilize quality improvement measures, based on health outcomes data, for internal quality assessment processes and may utilize such measures as part of the single coordinated surveillance process.

(ii) Notwithstanding any inconsistent provision of the social services law to the contrary, the commissioner shall, pursuant to regulation, determine whether and the extent to which the applicable provisions of the social services law or regulations relating to approvals and authorizations of, and utilization limitations on, health and long term care services reimbursed pursuant to title XIX of the federal social security act, including, but not limited to, fiscal assessment requirements, are inconsistent with the flexibility necessary for the

efficient administration of managed long term care plans and such regulations shall provide that such provisions shall not be applicable to enrollees or managed long term care plans, provided that such determinations are consistent with applicable federal law and regulation, and subject to the provisions of subdivision eight of section three hundred sixty-five-a of the social services law.

* (b) (i) The commissioner shall, to the extent necessary, 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 achieve the purposes of high quality, integrated, and cost effective care and integrated financial eligibility policies under the medical assistance program or pursuant to title XVIII of the federal social security act. In addition, the commissioner is authorized to 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 twelve, medical assistance recipients who are twenty-one years of age or older and who require community-based long term care services, as specified by the commissioner, for a continuous period of more than one hundred and twenty days, to receive such services through an available plan certified pursuant to this section or other program model that meets guidelines specified by the commissioner that support coordination and integration of services. Such guidelines shall address the requirements of paragraphs (a), (b), (c), (d), (e), (f), (g), (h), and (i) of subdivision three of this section as well as payment methods that ensure provider accountability for cost effective quality outcomes. Such other program models may include long term home health care programs that comply with such guidelines. Copies of such original 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 simultaneously with their submission to the federal government.

(ii) The commissioner, 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

further evaluate and promote the transition of persons in receipt of home and community-based long term care services into managed long term care plans and other care coordination models and to develop guidelines for such care coordination models. The guidelines shall be finalized and posted on the department's website no later than November fifteen, two thousand eleven.

(iii) Notwithstanding and in addition to any provision of subparagraph (i) of this paragraph and subject to any federal requirements, persons dually eligible for medical assistance and benefits under the federal Medicare program who are enrolled in a Medicare Dual Eligible Special Needs Plan and who do not require community-based long term care services, as specified by the commissioner, for a continuous period of more than one hundred and twenty days shall be required to enroll with an available affiliated plan certified pursuant to this section when program features and reimbursement rates are approved by the commissioner.

(v) The following medical assistance recipients shall not be eligible to participate in a managed long term care program or other care coordination model established pursuant to this paragraph until program features and reimbursement rates are approved by the commissioner and, as applicable, the commissioner of developmental disabilities:

(1) a person enrolled in a managed care plan pursuant to section three hundred sixty-four-j of the social services law;

(2) a participant in the traumatic brain injury waiver program or a person whose circumstances would qualify him or her for the program as it existed on January first, two thousand fifteen;

(3) a participant in the nursing home transition and diversion waiver program or a person whose circumstances would qualify him or her for the program as it existed on January first, two thousand fifteen;

(4) a person enrolled in the assisted living program;

(5) a person enrolled in home and community based waiver programs administered by the office for people with developmental disabilities;

(6) a person who is expected to be eligible for medical assistance for less than six months, for a reason other than that the person is eligible for medical assistance only through the application of excess income toward the cost of medical care and services;

(7) a person who is eligible for medical assistance benefits only with

respect to tuberculosis-related services;

(8) a person receiving hospice services at time of enrollment; provided, however, that this clause shall not be construed to require an individual enrolled in a managed long term care plan or another care coordination model, who subsequently elects hospice, to disenroll from such program;

(9) a person who has primary medical or health care coverage available from or under a third-party payor which may be maintained by payment, or part payment, of the premium or cost sharing amounts, when payment of such premium or cost sharing amounts would be cost-effective, as determined by the social services district;

(10) a person receiving family planning services pursuant to subparagraph six of paragraph (b) of subdivision one of section three hundred sixty-six of the social services law;

(11) a person who is eligible for medical assistance pursuant to paragraph (b) of subdivision four of section three hundred sixty-six of the social services law;

(12) Native Americans;

(13) a person who is permanently placed in a nursing home for a consecutive period of three months or more. In implementing this provision, the department shall continue to support service delivery and outcomes that result in community living for enrollees; and

(14) a person who has not been assessed as needing at least limited assistance with physical maneuvering with more than two activities of daily living, or for individuals with a dementia or Alzheimer's diagnosis, assessed as needing at least supervision with more than one activity of daily living, as defined and determined using an evidenced based validated assessment instrument approved by the commissioner and in accordance with applicable state and federal law and regulations of the department, provided that the provisions of this clause shall not apply to a person who has been continuously enrolled in a managed long term care program beginning prior to October first, two thousand twenty.

(v-a) For purposes of clause two of subparagraph (v) of this paragraph, program features shall be substantially comparable to those services available to traumatic brain injury waiver participants as of January first, two thousand fifteen, subject to federal financial participation.

(v-b) For purposes of clause three of subparagraph (v) of this paragraph, program features shall be substantially comparable to those services offered to nursing home transition and diversion waiver participants as of January first, two thousand fifteen, subject to federal financial participation.

(v-c) Any managed care program providing services under clause two or three of subparagraph (v) of this paragraph shall have an adequate network of trained providers to meet the needs of enrollees and provide services under this subdivision.

(v-d) Any individual providing service coordination pursuant to subparagraph (v-a) or (v-b) of this paragraph shall exercise his or her professional duties in the interests of the patient. Nothing in this subparagraph shall be construed as diminishing the authority and obligations of a managed long term care plan under this article and article forty-nine of this chapter.

(vi) persons required to enroll in the managed long term care program or other care coordination model established pursuant to this paragraph shall have no less than thirty days to select a managed long term care provider, and shall be provided with information to make an informed choice. Where a participant has not selected such a provider, the commissioner shall assign such participant to a managed long term care provider, taking into account consistency with any prior community-based direct care workers having recently served the recipient, quality performance criteria, capacity and geographic accessibility. During the period prior to receiving services from a managed long term care provider assigned under this subparagraph, the person may receive services under fee for service Medicaid.

(vii) If another long term care plan certified under this section is available, medical assistance recipients required to enroll in such plans pursuant to this section, including recipients who have been assigned to a provider by the commissioner, may change plans without cause within ninety days of either notification of enrollment or the effective date of enrollment into a plan, whichever is later, by submitting a request to the entity designated by the department in a format to be determined by the department. In accordance with federal statutes and regulations, after such ninety-day period, the department may prohibit a recipient from changing plans more frequently than once

every twelve months, except for good cause. Good cause may include poor quality of care, lack of access to covered services, lack of access to providers experienced in dealing with the enrollee's care needs, or as otherwise determined by the commissioner.

(viii) Managed long term care provided and plans certified or other care coordination model established pursuant to this paragraph shall comply with the provisions of paragraphs (d), (i), (t), and (u) and subparagraph (iii) of paragraph (a) and subparagraph (iv) of paragraph (e) of subdivision four of section three hundred sixty-four-j of the social services law.

(ix) (1) The commissioner shall report biannually 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 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.

* NB Effective until April 1, 2027

* (b) The commissioner shall, to the extent necessary, 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 achieve the purposes of high quality, integrated, and cost effective care and integrated financial eligibility policies under the medical assistance program or pursuant to title XVIII of the federal social security act. Copies of such original waiver applications shall be provided to the chairman of the senate finance committee and the chairman of the assembly ways and means committee simultaneously with their submission to the federal government.

* NB Effective April 1, 2027

(c)(i) A managed long term care plan shall not use deceptive or coercive marketing methods to encourage participants to enroll. A managed long term care plan shall not distribute marketing materials to potential enrollees before such materials have been approved by the commissioner.

(ii) The commissioner shall ensure, through periodic reviews of managed long term care plans, that enrollment was an informed choice; such plan has only enrolled persons whom it is authorized to enroll, and plan services are promptly available to enrollees when appropriate. Such periodic reviews shall be made according to standards as determined by the commissioner in regulations.

(d) Notwithstanding any provision of law, rule or regulation to the contrary, the commissioner may issue a request for proposals to carry out reviews of enrollment and assessment activities in managed long term care plans and operating demonstrations with respect to enrollees eligible to receive services under title XIX of the federal social security act to determine if enrollment meets the requirements of subparagraph (ii) of paragraph (c) of this subdivision; and that assessments of such enrollees' health, functional and other status, for the purpose of adjusting premiums, were accurate.

(e) The commissioner may, in his or her discretion for the purpose of protection of enrollees, impose measures including, but not limited to, bans on further enrollments and requirements for use of enrollment brokers until any identified problems are resolved to the satisfaction of the commissioner.

(f) Continuation of a certificate of authority issued under this section shall be contingent upon satisfactory performance by the managed

long term care plan in the delivery, continuity, accessibility, cost effectiveness and quality of the services to enrolled members; compliance with applicable provisions of this section and rules and regulations promulgated thereunder; the continuing fiscal solvency of the organization; and, federal financial participation in payments on behalf of enrollees who are eligible to receive services under title XIX of the federal social security act.

(g) * (i) Managed long term care plans and demonstrations may enroll eligible persons in the plan or demonstration upon the completion of a comprehensive assessment that shall include, but not be limited to, an evaluation of the medical, social, cognitive, and environmental needs of each prospective enrollee in such program. This assessment shall also serve as the basis for the development and provision of an appropriate plan of care for the enrollee, including appropriate community-based referrals. Upon approval of federal waivers pursuant to paragraph (b) of this subdivision which require medical assistance recipients who require community-based long term care services to enroll in a plan, and upon approval of the commissioner, a plan may enroll an applicant who is currently receiving home and community-based services and complete the comprehensive assessment within thirty days of enrollment provided that the plan continues to cover transitional care until such time as the assessment is completed.

* NB Effective until April 1, 2027

* (i) Managed long term care plans and demonstrations may enroll eligible persons in the plan or demonstration upon the completion of a comprehensive assessment that shall include, but not be limited to, an evaluation of the medical, social and environmental needs of each prospective enrollee in such program. This assessment shall also serve as the basis for the development and provision of an appropriate plan of care for the prospective enrollee, including appropriate community-based referrals.

* NB Effective April 1, 2027

(ii) The assessment shall be completed by a representative of the managed long term care plan or demonstration, in consultation with the prospective enrollee's health care practitioner as necessary. The commissioner shall prescribe the forms on which the assessment shall be made.

(iii) The enrollment application shall be submitted by the managed long term care plan or demonstration to the entity designated by the department prior to the commencement of services under the managed long term care plan or demonstration. Enrollments conducted by a plan or demonstration shall be subject to review and audit by the department or a contractor selected pursuant to paragraph (d) of this subdivision.

(iv) Continued enrollment in a managed long term care plan or demonstration paid for by government funds shall be based upon a comprehensive assessment of the medical, social and environmental needs of the recipient of the services. Such assessment shall be performed at least annually by the managed long term care plan serving the enrollee. The commissioner shall prescribe the forms on which the assessment will be made.

(h) * The commissioner and, in the case of a plan arranging for or providing services operated, certified, funded, authorized or approved by the office for people with developmental disabilities, the commissioner of the office for people with developmental disabilities, shall, upon request by a managed long term care plan or operating demonstration, and consistent with federal regulations promulgated pursuant to the Health Insurance Portability and Accountability Act, share with such plan or demonstration the following data if it is available:

* NB Effective until December 31, 2027

* The commissioner shall, upon request by a managed long term care plan or operating demonstration, and consistent with federal regulations promulgated pursuant to the Health Insurance Portability and Accountability Act, share with such plan or demonstration the following data if it is available:

* NB Effective December 31, 2027

(i) information concerning utilization of services and providers by each of its enrollees prior to and during enrollment, including but not limited to utilization of emergency department services, prescription drugs, and hospital and nursing facility admissions.

(ii) aggregate data concerning utilization and costs for enrollees and for comparable cohorts served through the Medicaid fee-for-service program.

(j) Limitations on licensed home care service agency contracts. (i)

The commissioner may establish methodologies to limit the number of licensed home care services agencies licensed pursuant to article thirty-six of the public health law with which managed long term care plans may enter into contracts, provided that such limitations are consistent with the specifications set forth in this paragraph.

(ii) Managed long term care plans operating in the city of New York and/or the counties of Nassau, Suffolk, and Westchester may enter into contracts with licensed home care services agencies in such region in a maximum number calculated based upon the following methodology:

(A) As of October first, two thousand eighteen, one contract per seventy-five members enrolled in the plan within such region; and

(B) As of October first, two thousand nineteen, one contract per one hundred members enrolled in the plan within such region.

(iii) Managed long term care plans operating in counties other than those in the city of New York and the counties of Nassau, Suffolk, and Westchester may enter into contracts with licensed home care services agencies in such region in a maximum number calculated based upon the following methodology:

(A) As of October first, two thousand eighteen, one contract per forty-five members enrolled in the plan within such region.

(B) As of October first, two thousand nineteen, one contract per sixty members enrolled in the plan within such region.

(iv) Notwithstanding subparagraphs (ii) and (iii) of this paragraph, a managed long term care plan shall not enter into less than the number of contracts with licensed home care services agencies in each county in which the plan operates as is necessary to remain consistent with network adequacy standards, as determined by the department in accordance with federal regulations.

(v) When calculating the number of additional contracts that a managed long term care plan may enter using the methodologies established pursuant to this paragraph, any fractional result shall be rounded down.

(vi) The commissioner may increase the number of licensed home care services agencies with which a managed long term care plan may contract, on a county by county basis, if the commissioner determines that such increase is necessary to: ensure adequate access to services in the geographic area including, but not limited to, special needs services and services that are culturally and linguistically appropriate; or to

avoid disruption in services in the geographic area.

(vii) Any licensed home care services agency that ceases operation as a result of this paragraph shall conform with all applicable requirements, including but not limited to demonstrating to the department's satisfaction continuity of care for individuals receiving services from the agency.

(viii) The commissioner may require managed long term care plans to provide evidence of compliance with this paragraph, on an annual basis.

(ix) In implementing the provisions of this paragraph, the commissioner shall, to the extent practicable, consider and select methodologies that seek to maximize continuity of care and minimize disruption to the provider labor workforce, and shall, to the extent practicable and consistent with the ratios set forth herein, continue to support contracts between managed long term care plans and licensed home care services agencies that are based on a commitment to quality and value.

(x) This subparagraph applies where implementation of the limits on contracts with licensed home care service agencies of this paragraph (i) would otherwise require an enrollee's care to be transferred from the enrollee's current licensed home care service agency to another licensed care service agency, and (ii) the enrollee (or the enrollee's authorized representative) wants the enrollee to continue to be cared for by one or more employees of the current licensed home care service agency, and that continuation would otherwise be provided. In such a case: the enrollee's managed long term care plan may contract with the enrollee's current licensed home care service agency for the purpose of continuing the enrollee's care by such employee or employees, and the contract shall not count towards the limits on contracts under this paragraph for a period of three months.

(k) Increased rates, terms or scope of payment for behavioral health services under this section, where payment is made by an entity under this section, as a result of a rate, coverage or other change made pursuant to a law, regulation, rule or official guidance, shall be deemed in effect on the same date that such change would have taken effect if payment were made other than by the entity. Where payment is not made as of the effective date, the entity shall make retroactive payments to the appropriate service providers.

8. Payment rates for managed long term care plan enrollees eligible for medical assistance. The commissioner shall establish payment rates for services provided to enrollees eligible under title XIX of the federal social security act. Such payment rates shall be subject to approval by the director of the division of the budget and shall reflect savings to both state and local governments when compared to costs which would be incurred by such program if enrollees were to receive comparable health and long term care services on a fee-for-service basis in the geographic region in which such services are proposed to be provided. Payment rates shall be risk-adjusted to take into account the characteristics of enrollees, or proposed enrollees, including, but not limited to: frailty, disability level, health and functional status, age, gender, the nature of services provided to such enrollees, and other factors as determined by the commissioner. The risk adjusted premiums may also be combined with disincentives or requirements designed to mitigate any incentives to obtain higher payment categories. In setting such payment rates, the commissioner shall consider costs borne by the managed care program to ensure actuarially sound and adequate rates of payment to ensure quality of care shall comply with all applicable laws and regulations, state and federal, including regulations as to actuarial soundness for medicaid managed care.

8-a. Rates for certain residential health care facilities. Notwithstanding any other provision of law or regulation to the contrary, any residential health care facility established pursuant to article twenty-eight of this chapter located in a county with a population of more than seventy-two thousand and less than seventy-five thousand persons based on the two thousand ten federal census shall be reimbursed by any managed long term care plan, approved pursuant to this section and contracting with the department, at a rate of no less than one hundred four percent of the average rate of reimbursement in existence on March first, two thousand eighteen for such county.

9. Reports. The department shall provide an interim report to the governor, temporary president of the senate and the speaker of the assembly on or before April first, two thousand three and a final report

on or before April first, two thousand six on the results of the managed long term care plans under this section. Such results shall be based on data provided by the managed long term care plans and shall include but not be limited to the quality, accessibility and appropriateness of services; consumer satisfaction; the mean and distribution of impairment measures of the enrollees by payor for each plan; the current method of calculating premiums and the cost of comparable health and long term care services provided on a fee-for-service basis for enrollees eligible for services under title XIX of the federal social security act; and the results of periodic reviews of enrollment levels and practices. Such reports shall provide data on the demographic and clinical characteristics of enrollees, voluntary and involuntary disenrollments from plans, and utilization of services and shall examine the feasibility of increasing the number of plans that may be approved. Data collected pursuant to this section shall be available to the public in an aggregated format to protect individual confidentiality, however under no circumstance will data be released on items with cells with smaller than statistically acceptable standards.

10. Notwithstanding any inconsistent provision to the contrary, the enrollment and disenrollment process and services provided or arranged by all operating demonstrations or any program that receives designation as a Program of All-Inclusive Care for the Elderly (PACE) as authorized by federal public law 105-33, subtitle I of title IV of the Balanced Budget Act of 1997, must meet all applicable federal requirements. Services may include, but need not be limited to, housing, inpatient and outpatient hospital services, nursing home care, home health care, adult day care, assisted living services provided in accordance with article forty-six-B of this chapter, adult care facility services, enriched housing program services, hospice care, respite care, personal care, homemaker services, diagnostic laboratory services, therapeutic and diagnostic radiologic services, emergency services, emergency alarm systems, home delivered meals, physical adaptations to the client's home, physician care (including consultant and referral services), ancillary services, case management services, transportation, and related medical services.

11. The department shall develop transition and continuity of care policies for participants in home and community based long term care, including the long term home health care program, as they move to managed long term care plans addressing:

(a) a timetable and plan for implementation and transition by participants, plans and providers;

(b) informative disclosure of participants' options as to impending actions affecting or relating to the home care services they receive;

(c) reasonable opportunity for plans' and providers' good faith pursuit of contracts, program changes or state approvals relevant to plan implementation;

(d) notice that a participant with a previously established plan of care provided by a certified home health agency or long term home health care program, or provided pursuant to the personal care or consumer directed personal assistance service programs, may elect to have such care plan continued subject to the participant's next comprehensive assessment; and

(e) delineation of responsibilities for service delivery and care coordination, so as to avoid conflict, duplication and unnecessary disruption of direct care staffing for the patient, and maintain compliance with state and federal statute and regulation, including the provisions of this section, article thirty-six of this chapter and section three hundred sixty-five-f of the social services law.

In addition, the department shall provide technical assistance to long term home health care providers with contracting options under this section. The department shall work with affected stakeholders in the development of these policies.

11-a. In transitioning individuals to managed long term care, the department shall provide oversight of long term managed care by ensuring:

(a) participants are appropriately notified of the upcoming changes to their health care, and their rights and options;

(b) access to appropriate enrollment assistance, consumer assistance and complaint mechanisms;

(c) access to quality care by requiring network transparency and

choice of long term care plans, allowing patients to choose the plan that best fits their needs;

(d) transparency and accountability from providers, which shall include a mechanism by which staff, participants and family members can confidentially report concerns relating to quality to the plan and the state;

(e) plans and providers are assessed periodically and data is published regarding enrollment in integrated care designs, network adequacy, new service designs, outcome measures, including the extent to which care plans are continued or altered based upon new comprehensive assessments, and the types and amounts of services health plans have authorized;

(f) mechanisms are in place to state oversight of enrollment and services to prevent waste and abuse in the managed long term care system; and

(g) incentives are provided for a variety of indicators, including but not limited to, smooth patient transitions, appropriate enrollment, quality care, high staff retention and positive health care outcomes achieved at a low cost.

11-b. In cases of a managed long term care plan merger, acquisition, or other similar arrangement approved by the department, any receiving plan that is a party to the arrangement shall submit a report to the department within twelve months of the effective date of the transaction. Such reports shall be in a form and format to be determined by the department and shall include, but not be limited to, information about the enrollees transferred and enrollee service authorization data before and after transfer. The department shall make a summary of the report available to the public.

** 12. The commissioner may make any necessary amendments to a contract pursuant to this section with a managed long term care plan, as defined in paragraph (a) of subdivision one of this section, to allow such managed long term care plan to participate as a qualified health plan in a state health benefit exchange established pursuant to the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

** NB There are 2 sb 12's

** 12. Notwithstanding any provision to the contrary, a managed long term care plan may expand the services it provides or arranges for to include services operated, certified, funded, authorized or approved by the office for people with developmental disabilities for a population of persons with developmental disabilities, as such term is defined in the mental hygiene law, including habiltiation services as defined in paragraph (c) of subdivision one of section forty-four hundred three-g of this article, subject to the following:

(a) Such plan must have the ability to provide or coordinate services for persons with developmental disabilities as demonstrated by criteria to be determined by the commissioner and the commissioner of the office for people with developmental disabilities. Such criteria shall include, but not be limited to, adequate experience providing or coordinating services for persons with developmental disabilities;

(a-1) If the commissioner and the commissioner of the office for people with developmental disabilities determine that such plan lacks the experience required in paragraph (a) of this subdivision, the plan shall have an affiliation arrangement with an entity or entities that are non-profit organizations or organizations whose shareholders are solely controlled by non-profit organizations with experience serving persons with developmental disabilities, as demonstrated by criteria to be determined by the commissioner and the commissioner of the office for people with developmental disabilities, with such criteria including, but not limited to, residential, day and employment services, such that the affiliated entity will coordinate and plan services operated, certified, funded, authorized or approved by the office for people with developmental disabilities or will oversee and approve such coordination and planning;

(a-2) Each enrollee shall receive services designed to achieve person-centered outcomes, to enable that person to live in the most integrated setting appropriate to that person's needs, and to enable that person to interact with nondisabled persons to the fullest extent possible in social, workplace and other community settings, provided that all such services are consistent with such person's wishes to the extent that such wishes are known. With respect to an individual receiving non-residential services operated, certified, funded,

authorized or approved by the office for people with developmental disabilities prior to enrollment in the plan, such guidelines shall require the plan to contract with the current provider of such non-residential services at the rates established by the office for ninety days in order to ensure continuity of care. With respect to an individual living in a residential facility operated or certified by the office for people with developmental disabilities prior to enrollment in the plan, the plan shall contract with the provider of residential services for that residence at the rates established by the office for people with developmental disabilities for so long as such individual lives in that residence pursuant to an approved plan of care;

(b) The provision by such plan of services operated, certified, funded, authorized or approved by the office for people with developmental disabilities shall be subject the joint oversight and review of both the department and the office for people with developmental disabilities. The department and such office shall require such organization to provide comprehensive care planning, assess quality, meet quality assurance requirements and ensure the enrollee is involved in care planning;

(c) Such plan shall not provide or arrange for services operated, certified, funded, authorized or approved by the office for people with developmental disabilities until the commissioner and the commissioner of the office for people with developmental disabilities approve program features and rates that include such services, and determine that such organization meets the requirements of this subdivision and any other requirements set forth by the commissioner of the office for people with developmental disabilities;

(d) An otherwise eligible enrollee receiving services through the plan that are operated, certified, funded, authorized or approved by the office for people with developmental disabilities shall not be involuntarily disenrolled from such plan without the prior approval of the commissioner of the office for people with developmental disabilities. Notice shall be provided to the enrollee and the enrollee may request a fair hearing regarding such disenrollment;

(e) The office for people with developmental disabilities shall determine the eligibility of individuals receiving services operated, certified, funded, authorized or approved by such office to enroll in

such plan and shall enroll individuals it determines eligible in a plan chosen by such individual, guardian or other legal representative;

(f) The office for people with developmental disabilities, or its designee, shall complete a comprehensive assessment for enrollees who receive services operated, certified, funded, authorized or approved by such office. This assessment shall include, but not be limited to, an evaluation of the medical, social, habilitative and environmental needs of each prospective enrollee as such needs relate to each individual's health, safety, living environment and wishes, to the extent that such wishes are known. This assessment shall also serve as the basis for the development and provision of an appropriate plan of care for the enrollee. Such plan of care shall be focused on the achievement of person-centered outcomes and shall be consistent with and help inform any other person-centered plan required for the enrollee by the commissioner of the office for people with developmental disabilities. The initial assessment shall be completed by such office or a designee other than the plan and shall be completed in consultation with the prospective enrollee's health care practitioner as necessary. Reassessments shall be completed by such office or its designee, which may be the managed long term care plan in which the person is enrolled or proposes to enroll. The commissioner of the office for people with developmental disabilities shall prescribe the forms on which the assessment shall be made.

(f-1) The plan shall provide the department and the office for people with developmental disabilities with a description of the proposed marketing plan and how marketing materials will be presented to persons with developmental disabilities or their authorized decision makers for the purposes of enabling them to make an informed choice.

(g) Plans providing services operated, certified, funded, authorized or approved by the office for people with developmental disabilities shall be subject to all requirements applicable to DISCOs operating under section forty-four hundred three-g of this article with respect to quality assurance, grievances and appeals, informed choice, participation in development of plans of care and requirements with respect to marketing, to the extent that such requirements are not inconsistent with this section.

(h) No person with a developmental disability shall be required to

enroll in a managed long term care plan as a condition of receiving medical assistance and services operated, certified, funded, authorized or approved by the office for people with developmental disabilities until program features and reimbursement rates are approved by the commissioner and the commissioner of the office for people with developmental disabilities and until such commissioners determine that there are a sufficient number of plans authorized to coordinate care for persons with developmental disabilities pursuant to this article operating in the person's county of residence to meet the needs of persons with developmental disabilities, and that such plans meet the standards of this section.

** NB Repealed December 31, 2027

** NB There are 2 sb 12's

** 13. Notwithstanding any inconsistent provision to the contrary, the commissioner may issue a certificate of authority to no more than three eligible applicants who are eligible for Medicare and medical assistance to operate managed long term care plans that are authorized to exclusively enroll persons with developmental disabilities, as such term is defined in section 1.03 of the mental hygiene law. The commissioner may only issue certificates of authority pursuant to this subdivision if, and to the extent that, the department has received federal approval to operate a fully integrated duals advantage program for the integration of services for persons enrolled in Medicare and medical assistance. The commissioner may waive any of the department's regulations as the 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 services for persons with developmental disabilities that are adequate and appropriate to meet the needs of such individuals and that will ensure their health and safety.

** NB Repealed December 31, 2027

** 14. The provisions of subdivisions twelve and thirteen of this section shall only be effective if, for so long as, and to the extent that federal financial participation is available for the costs of services provided thereunder to recipients of medical assistance pursuant to title eleven of article five of the social services law. The commissioner shall make any necessary amendments to the state plan for

medical assistance submitted pursuant to section three hundred sixty-three-a of the social services law, and/or submit one or more applications for waivers of the federal social security act, as may be necessary to ensure such federal financial participation. To the extent that the provisions of subdivision twelve and thirteen of this section are inconsistent with other provisions of this article or with the provisions of section three hundred sixty-four-j of the social services law, the provisions of this subdivision shall prevail.

** NB Repealed December 31, 2027

* NB Repealed December 31, 2029