2. All Medicaid-covered items and services, as specified in the state's Medicaid plan and under section three hundred sixty-four-j of the social services law; and

3. Other such services as determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status.

§ 2999-x. Reimbursement. The department shall develop and implement, in conformance with applicable federal requirements, a methodology for establishing rates of payment for costs of benefits provided by PACE organizations to its Medicaid eligible enrollees.

§ 4. This act shall take effect immediately; provided, however, that section three of this act shall take effect upon the adoption of rules and regulations by the commissioner of health governing the licensure of PACE organizations as provided under article 29-EE of the public health law as added by section three of this act; provided that the commissioner of health shall notify the legislative bill drafting commission upon the occurrence of the adoption of rules and regulations pursuant to such section in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effectuating the provisions of section 44 of the legislative law and section 70-b of the public officers law. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

PART P

Section 1. Subdivision 2 of section 364-j of the social services law is amended by adding a new paragraph (d) to read as follows:

(d) Effective April first, two thousand twenty-two and expiring on the date the commissioner of health publishes on its website a request for proposals in accordance with paragraph (a) of subdivision five of this section, the commissioner of health shall place a moratorium on the processing and approval of applications seeking authority to establish a managed care provider, including applications seeking authorization to expand the scope of eligible enrollee populations. Such moratorium shall not apply to:

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

(ii) applications seeking approval to transfer ownership or control of an existing managed care provider;

(iii) applications seeking authorization to expand an existing managed care provider's approved service area;

(iv) applications seeking authorization to form or operate a managed care provider through an entity certified under section four thousand four hundred three-c or four thousand four hundred three-g of the public health law;

(v) applications demonstrating to the commissioner of health'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 care providers in a geographic area or a lack of adequate and appropriate care, language and cultural competence, or special needs services.

§ 2. Subdivision 5 of section 364-j of the social services law, as amended by section 15 of part C of chapter 58 of the laws of 2004, para-

graph (a) as amended by section 40 of part A of chapter 56 of the laws of 2013, paragraphs (d), (e) and (f) as amended by section 80 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

5. Managed care programs shall be conducted in accordance with the requirements of this section and, to the extent practicable, encourage the provision of comprehensive medical services, pursuant to this article.

(a) The managed care program notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law, sections one hundred forty-two and one hundred forty-three of the economic development law, and any other inconsistent provision of law, the commissioner of health shall, through a competitive bid process based on proposals submitted to the department, provide for the selection of qualified managed care providers [by the commissioner of health] to participate in the managed care program pursuant to a contract with the department, including [comprehensive HIV special needs plans and] special needs managed care plans in accordance with the provisions of section three hundred sixty-five-m of this title; provided, however, that the commissioner of health may contract directly with comprehensive HIV special needs plans [consistent with standards set forth in this section] without a competitive bid process, and assure that such providers are accessible taking into account the needs of persons with disabilities and the differences between rural, suburban, and urban settings, and in sufficient numbers to meet the health care needs of participants, and shall consider the extent to which major public hospitals are included within such providers' networks[.

(b) A proposal]; and provided further that:

(i) Proposals submitted by a managed care provider to participate in the managed care program shall:

[(i)] (A) designate the geographic [area] areas, as defined by the commissioner of health in the request for proposals, to be served [by the provider], and estimate the number of eligible participants and actual participants in such designated area;

[(ii)] (B) include a network of health care providers in sufficient numbers and geographically accessible to service program participants;

[(iii)] (C) describe the procedures for marketing in the program location, including the designation of other entities which may perform such functions under contract with the organization;

[(iv)] (D) describe the quality assurance, utilization review and case management mechanisms to be implemented;

[(v)] (E) demonstrate the applicant's ability to meet the data analysis and reporting requirements of the program;

[(vi)] (F) demonstrate financial feasibility of the program; and

[(vii)] (G) include such other information as the commissioner of health may deem appropriate.

(ii) In addition to the criteria described in subparagraph (i) of this paragraph, the commissioner of health shall also consider:

(A) 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;

(B) the extent to which major public hospitals are included in the submitted provider network;

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

(D) the corporate organization and status of the bidder as a charitable corporation under the not-for-profit corporation law;

(E) the ability of a bidder to offer plans in multiple regions;

(F) the type and number of products the bidder proposes to operate, including products bid for in accordance with the provisions of subdivision six of section four thousand four hundred three-f of the public health law, and other products determined by the commissioner of health, including but not necessarily limited to those operated under title one-A of article twenty-five of the public health law and section three hundred sixty-nine-gg of this article;

(G) whether the bidder participates in products for integrated care for participants who are dually eligible for medicaid and medicare;

(H) whether the bidder participates in value based payment arrangements as defined by the department, including the delegation of significant financial risk to clinically integrated provider networks;

(I) the bidder's commitment to participation in managed care in the state;

(J) the bidder's commitment to quality improvement;

(K) the bidder's commitment to community reinvestment spending, as shall be defined in the procurement;

(L) for current or previously authorized managed care providers, past performance in meeting managed care contract or federal or state requirements, and if the commissioner issued any statements of findings, statements of deficiency, intermediate sanctions or enforcement actions to a bidder for non-compliance with such requirements, whether the bidder addressed such issues in a timely manner;

(M) such criteria as the commissioner of health shall develop, with the commissioners of the office of mental health, the office for people

with developmental disabilities, the office of addiction services and supports, and the office of children and family services, as applicable; and

(N) any other criteria deemed appropriate by the commissioner of health.

(iii) Subparagraphs (i) and (ii) of this paragraph describing proposal content and selection criteria requirements shall not be construed as limiting or requiring the commissioner of health to evaluate such content or criteria on a pass-fail, scale, or other methodological basis; provided however, that the commissioner shall consider all such content and criteria using methods determined by the commissioner of health in their discretion and, as applicable, in consultation with the commissioners of the office of mental health, the office for people with developmental disabilities, the office of addiction services and supports, and the office of children and family services.

(iv) The department of health shall post on its website:

(A) The request for proposals and a description of the proposed services to be provided pursuant to contracts in accordance with this subdivision;

(B) The criteria on which the department shall determine qualified bidders and evaluate their proposals, including all criteria identified in this subdivision;

(C) The manner by which a proposal may be submitted, which may include submission by electronic means;

(D) The manner by which a managed care provider may continue to participate in the managed care program pending award of managed care providers through a competitive bid process pursuant to this subdivision; and

(E) Upon award, the managed care providers that the commissioner intends to contract with pursuant to this subdivision, provided that the commissioner shall update such list to indicate the final slate of contracted managed care providers.

(v)(A) All responsive submissions that are received from bidders in a timely fashion shall be reviewed by the commissioner of health in consultation with the commissioners of the office of mental health, the office for people with developmental disabilities, the office of addiction services and supports, and the office of children and family services, as applicable. The commissioner shall consider comments resulting from the review of proposals and make awards in consultation with such agencies.

(B) The commissioner of health shall make awards under this subdivision for each product, for which proposals were requested, to at least two managed care providers in each geographic region defined by the commissioner in the request for proposals for which at least two managed care providers have submitted a proposal, and shall have discretion to offer more contracts based on need for access; provided, however, that the commissioner of health shall not offer any more than five (5) contracts in any one region.

(C) Managed care providers awarded under this subdivision shall be entitled to enter into a contract with the department for the purpose of participating in the managed care program. Such contracts shall run for a term to be determined by the commissioner, which may be renewed or modified from time to time without a new request for proposals, to ensure consistency with changes in federal and state laws, regulations or policies, including but not limited to the expansion or reduction of

medical assistance services available to participants through a managed care provider.

(D) Nothing in this paragraph or other provision of this section shall be construed to limit in any way the ability of the department of health to terminate awarded contracts for cause, which shall include but not be limited to any violation of the terms of such contracts or violations of state or federal laws and regulations and any loss of necessary state or federal funding.

(E) Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law, sections one hundred forty-two and one hundred forty-three of the economic development law, and any other inconsistent provision of law, the department of health may, in accordance with the provisions of this paragraph, issue new requests for proposals and award new contracts for terms following an existing term of a contract entered into under this paragraph.

(b)(i) Within sixty days of the department of health issuing the request for proposals under paragraph (a) of this subdivision, a managed care provider that was approved to participate in the managed care program prior to the issuance of the request for proposals, shall submit its intention to complete such proposal to the department.

(ii) A managed care provider that: (A) fails to submit its intent timely, (B) indicates within the sixty-days its intent not to complete such a proposal, (C) fails to submit a proposal within the further time-frame specified by the commissioner of health in the request for proposals, or (D) is not awarded the ability to participate in the managed care program under paragraph (a) of this subdivision, shall, upon direction from the commissioner of health, terminate its services and operations in accordance with the contract between the managed care

provider and the department of health and shall be additionally required to maintain coverage of participants for such period of time as determined necessary by the commissioner of health to achieve the safe and orderly transfer of participants.

(c) [The commissioner of health shall make a determination whether to approve, disapprove or recommend modification of the proposal] If necessary to ensure access to sufficient number of managed care providers on a geographic or other basis, including a lack of adequate and appropriate care, language and cultural competence, or special needs services, the commissioner of health may reissue a request for proposals as provided for under paragraph (a) of this subdivision, provided however, that such request may be limited to the geographic or other basis of need that the request for proposals is seeking to address. Any awards made shall be subject to the requirements of this section, including but not limited to the minimum and maximum number of awards in a region.

(d) [Notwithstanding any inconsistent provision of this title and section one hundred sixty-three of the state finance law, the commissioner of health may contract with managed care providers approved under paragraph (b) of this subdivision, without a competitive bid or request for proposal process, to provide coverage for participants pursuant to this title.

(e) Notwithstanding any inconsistent provision of this title and section one hundred forty-three of the economic development law, no notice in the procurement opportunities newsletter shall be required for contracts awarded by the commissioner of health, to qualified managed care providers pursuant to this section.

(f)] The care and services described in subdivision four of this section will be furnished by a managed care provider pursuant to the

provisions of this section when such services are furnished in accordance with an agreement with the department of health, and meet applicable federal law and regulations.

[(g)] (e) The commissioner of health may delegate some or all of the tasks identified in this section to the local districts.

[(h)] (f) Any delegation pursuant to paragraph [(g)] (e) of this subdivision shall be reflected in the contract between a managed care provider and the commissioner of health.

§ 3. Subdivision 4 of section 365-m of the social services law is REPEALED and a new subdivision 4 is added to read as follows:

4. The commissioner of health, jointly with the commissioners of the office of mental health and the office of addiction services and supports, shall select a limited number of special needs managed care plans under section three hundred sixty-four-j of this title, in accordance with subdivision five of such section, capable of managing the behavioral and physical health needs of medical assistance enrollees with significant behavioral health needs.

§ 4. The opening paragraph of subdivision 2 of section 4403-f of the public health law, as amended by section 8 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

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, including any such forms or process as may be required or prescribed by the commissioner in accordance with the competitive bid process under subdivision six of this section. Such eligible applicant shall submit information and documentation to the commissioner which shall include, but not be limited to:

§ 5. Subdivision 3 of section 4403-f of the public health law, as amended by section 41-a of part H of chapter 59 of the laws of 2011, is amended to read as follows:

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

[(a)] (i) 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)] (ii) 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)] (iii) 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)] (iv) sufficient management systems capacity to meet the requirements of this section and the ability to efficiently process payment for covered services;

[(e)] (v) 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)] (vi) 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)] (vii) 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)] (viii) 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)] (ix) that the applicant is financially responsible and may be expected to meet its obligations to its enrolled members.

(b) Notwithstanding the provisions of paragraph (a) of this subdivision, the approval of any application for certification as a managed long term care plan under this section for a plan that seeks to cover a population of enrollees eligible for services under title XIX of the federal social security act, shall be subject to and conditioned on selection through the competitive bid process provided under subdivision six of this section.

§ 6. Subdivision 6 of section 4403-f of the public health law, as amended by section 41-b of part H of chapter 59 of the laws of 2011, paragraph (a) as amended by section 4 and paragraphs (d), (e) and (f) as added by section 5 of part MM of chapter 56 of the laws of 2020, is amended to read as follows:

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; provided, however, that any managed long term care plan seeking to provide health and long term care services to a population of enrollees that are eligible under title XIX of the federal social security act shall not receive a certificate of authority, nor be eligible for a contract to provide such services with the department, unless selected through the competitive bid process described in this subdivision. [The commissioner shall issue no more than seventy-five certificates of authority to managed long term care plans pursuant to this section. 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.

(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.]

(a) Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law, sections one hundred forty-two and one hundred forty-three of the economic development law, and any other inconsistent provision of law, the commissioner of health shall, through a competitive bid process based on proposals submitted to the department, provide for the selection of qualified managed long term care plans to provide health and long term care services to enrollees who are eligible under title XIX of the federal social security act pursuant to a contract with the department; provided, however, that:

(i) A proposal submitted by a managed long term care plan shall include information sufficient to allow the commissioner to evaluate the

bidder in accordance with the requirements identified in subdivisions two through four of this section.

(ii) In addition to the criteria described in subparagraph (i) of this paragraph, the commissioner shall also consider:

(A) 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;

(B) the extent to which major public hospitals are included in the submitted provider network, if applicable;

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

(D) the corporate organization and status of the bidder as a charitable corporation under the not-for-profit corporation law;

(E) the ability of a bidder to offer plans in multiple regions;

(F) the type and number of products the bidder proposes to operate, including products applied for in accordance with the provisions of subdivision five of section three hundred sixty-four-j of the social services law, and other products determined by the commissioner, including but not necessarily limited to 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;

(G) whether the bidder participates in products for integrated care for participants who are dually eligible for medicaid and medicare;

(H) whether the bidder participates in value based payment arrangements as defined by the department, including the delegation of significant financial risk to clinically integrated provider networks;

(I) the bidder's commitment to participation in managed care in the state;

(J) the bidder's commitment to quality improvement;

(K) the bidder's commitment to community reinvestment spending, as shall be defined in the procurement;

(L) for current or previously authorized managed care providers, past performance in meeting managed care contract or federal or state requirements, and if the commissioner issued any statements of findings, statements of deficiency, intermediate sanctions or enforcement actions to a bidder for non-compliance with such requirements, whether the bidder addressed such issues in a timely manner;

(M) such criteria as the commissioner shall develop, with the commissioners of the office of mental health, the office for people with developmental disabilities, the office of addiction services and supports, and the office of children and family services; and

(N) any other criteria deemed appropriate by the commissioner.

(iii) Subparagraphs (i) and (ii) of this paragraph describing proposal content and selection criteria requirements shall not be construed as limiting or requiring the commissioner to evaluate such content or criteria on a pass-fail, scale, or other particular methodological basis; provided however, that the commissioner must consider all such content and criteria using methods determined by the commissioner in their discretion and, as applicable, in consultation with the commissioners of the office of mental health, the office for people with developmental disabilities, the office of addiction services and supports, and the office of children and family services.

(iv) The department shall post on its website:

(A) The request for proposals and a description of the proposed services to be provided pursuant to contracts in accordance with this subdivision;

(B) The criteria on which the department shall determine qualified bidders and evaluate their applications, including all criteria identified in this subdivision;

(C) The manner by which a proposal may be submitted, which may include submission by electronic means;

(D) The manner by which a managed long term care plan may continue to provide health and long term care services to enrollees who are eligible under title XIX of the federal social security act pending awards to managed long term care plans through a competitive bid process pursuant to this subdivision; and

(E) Upon award, the managed long term care plans that the commissioner intends to contract with pursuant to this subdivision, provided that the commissioner shall update such list to indicate the final slate of contracted managed long term care plans.

(v) (A) All responsive submissions that are received from bidders in a timely fashion shall be reviewed by the commissioner of health in consultation with the commissioners of the office of mental health, the office for people with developmental disabilities, the office of addiction services and supports, and the office of children and family services, as applicable. The commissioner shall consider comments resulting from the review of proposals and make awards in consultation with such agencies.

(B) The commissioner shall make awards under this subdivision, for each product for which proposals were requested, to at least two managed long term care plans in each geographic region defined by the commissioner in the request for proposals for which at least two managed long term care plans have submitted a proposal, and shall have discretion to offer more contracts based on need for access; provided, however, that

the commissioner shall not offer any more than five (5) contracts in any one region.

(C) Managed long term care plans awarded under this subdivision shall be entitled to enter into a contract with the department for the purpose of providing health and long term care services to enrollees who are eligible under title XIX of the federal social security act. Such contracts shall run for a term to be determined by the commissioner, which may be renewed or modified from time to time without a new request for proposals, to ensure consistency with changes in federal and state laws, regulations or policies, including but not limited to the expansion or reduction of medical assistance services available to participants through a managed long term care plan.

(D) Nothing in this paragraph or other provision of this section shall be construed to limit in any way the ability of the department to terminate awarded contracts for cause, which shall include but not be limited to any violation of the terms of such contracts or violations of state or federal laws and regulations and any loss of necessary state or federal funding.

(E) Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law, sections one hundred forty-two and one hundred forty-three of the economic development law, and any other inconsistent provision of law, the department may, in accordance with the provisions of this paragraph, issue new requests for proposals and award new contracts for terms following an existing term of a contract entered into under this paragraph.

(b) (i) Within sixty days of the department issuing the request for proposals under paragraph (a) of this subdivision, a managed long term care plan that was approved to provide health and long term care

services to enrollees who are eligible under title XIX of the federal social security act prior to the issuance of the request for proposals, shall submit its intention to complete such proposal to the department.

(ii) A managed long term care plan that: (A) fails to submit its intent timely, (B) indicates within the sixty days its intent not to complete such a proposal, (C) fails to submit a proposal within the further timeframe specified by the commissioner in the request for proposals, or (D) is not awarded the ability to provide health and long term care services to enrollees who are eligible under title XIX of the federal social security act under paragraph (a) of this subdivision, shall, upon direction from the commissioner, terminate its services and operations in accordance with the contract between the managed long term care plan and the department and shall be additionally required to maintain coverage of enrollees for such period of time as determined necessary by the commissioner to achieve the safe and orderly transfer of enrollees.

(c) Addressing needs for additional managed long term care plans to ensure access and choice for enrollees eligible under title XIX of the federal social security act. If necessary to ensure access to sufficient number of managed long term care plans on a geographic or other basis, including a lack of adequate and appropriate care, language and cultural competence, or special needs services, the commissioner may reissue a request for proposals as provided for under paragraph (a) of this subdivision, provided however that such request may be limited to the geographic or other basis of need that the request for proposals seeks to address. Any awards made shall be subject to the requirements of this section, including but not limited to the minimum and maximum number of awards in a region.

(d) (i) Effective April first, two thousand twenty, and expiring [March thirty-first, two thousand twenty-two] on the date the commissioner publishes on its website a request for proposals in accordance with subparagraph (iv) of paragraph (a) of the subdivision, 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] <u>From April first, two thousand twenty, until March thirty-first, two thousand twenty-two</u>, 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.]

§ 7. Subparagraphs (v) and (vi) of paragraph (b) of subdivision 1 of section 268-d of the public health law, as added by section 2 of part T of chapter 57 of the laws of 2019, are amended to read as follows:

(v) meets standards specified and determined by the Marketplace, provided that the standards do not conflict with or prevent the application of federal requirements; [and]

(vi) <u>contracts with any national cancer institute-designated cancer center licensed by the department within the health plan's service area that is willing to agree to provide cancer-related inpatient, outpatient and medical services to enrollees in all health plans offering coverage</u>

through the Marketplace in such cancer center's service area under the prevailing terms and conditions that the plan requires of other similar providers to be included in the plan's provider network, provided that such terms shall include reimbursement of such center at no less than the fee-for-service medicaid payment rate and methodology applicable to the center's inpatient and outpatient services; and

(vii) complies with the insurance law and this chapter requirements applicable to health insurance issued in this state and any regulations promulgated pursuant thereto that do not conflict with or prevent the application of federal requirements; and

§ 8. Subdivision 4 of section 364-j of the social services law is amended by adding a new paragraph (w) to read as follows:

(w) A managed care provider shall provide or arrange, directly or indirectly, including by referral, for access to and coverage of services provided by any national cancer institute-designated cancer center licensed by the department of health within the managed care provider's service area that is willing to agree to provide cancer-related inpatient, outpatient and medical services to participants in all managed care providers offering coverage to medical assistance recipients in such cancer center's service area under the prevailing terms and conditions that the managed care provider requires of other similar providers to be included in the managed care provider's network, provided that such terms shall include reimbursement of such center at no less than the fee-for-service medicaid payment rate and methodology applicable to the center's inpatient and outpatient services.

§ 9. Paragraph (c) of subdivision 1 of section 369-gg of the social services law, as amended by section 2 of part H of chapter 57 of the laws of 2021, is amended to read as follows:

(c) "Health care services" means (i) the services and supplies as defined by the commissioner in consultation with the superintendent of financial services, and shall be consistent with and subject to the essential health benefits as defined by the commissioner in accordance with the provisions of the patient protection and affordable care act (P.L. 111-148) and consistent with the benefits provided by the reference plan selected by the commissioner for the purposes of defining such benefits, and shall include coverage of and access to the services of any national cancer institute-designated cancer center licensed by the department of health within the service area of the approved organization that is willing to agree to provide cancer-related inpatient, outpatient and medical services to all enrollees in approved organizations' plans in such cancer center's service area under the prevailing terms and conditions that the approved organization requires of other similar providers to be included in the approved organization's network, provided that such terms shall include reimbursement of such center at no less than the fee-for-service medicaid payment rate and methodology applicable to basic health program plan payments for inpatient and outpatient services; and (ii) dental and vision services as defined by the commissioner;

§ 10. Severability. If any clause, sentence, paragraph, section or part of this act shall be adjudged by any court of competent jurisdiction to be invalid and after exhaustion of all further judicial review, the judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, section or part of this act directly involved in the controversy in which the judgment shall have been rendered.

§ 11. Sections one, two, three, four, five, six and ten of this act shall take effect immediately; sections seven, eight and nine shall take effect on the first of January next succeeding the date on which it shall have become a law and shall apply to all coverage or policies issued or renewed on or after such effective date and shall expire and be deemed repealed five years after such date; provided, however, that the amendments to section 364-j of the social services law made by sections one, two and eight of this act, the amendments to section 4403-f of the public health law made by sections four, five and six of this act and the amendments to paragraph (c) of subdivision 1 of section 369-gg of the social services law made by section nine of this act shall not affect the repeal of such sections or such paragraph and shall be deemed repealed therewith; provided, further, that this act shall not be construed to prohibit managed care providers participating in the managed care program and managed long term care plans approved to provide health and long term care services to enrollees who are eligible under title XIX of the federal social security act, that were so authorized as of the date this act becomes effective, from continuing operations as authorized until such time as awards are made in accordance with this act and such additional time subject to direction from the commissioner of health to ensure the safe and orderly transfer of participants.

PART Q

Section 1. Section 268-c of the public health law is amended by adding a new subdivision 25 to read as follows: