S T A T E O F N E W Y O R K

6658

2009-2010 Regular Sessions

I N A S S E M B L Y

March 11, 2009

Introduced by M. of A. SCHIMMINGER, DelMONTE -- Multi-Sponsored by -- M. of A. HOOPER, J. RIVERA, N. RIVERA, TOWNS -- read once and referred to the Committee on Health

AN ACT to amend the social services law, in relation to requiring the state to pay medicare part A premiums for persons eligible for medicare part A and medical assistance and to require local commissioners of social services to appeal denial of medicare coverage before approving medical assistance coverage for long term care

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Subdivisions 1 and 2 of section 364-i of the social services law, as amended by chapter 693 of the laws of 1996, are amended to read as follows:

1. An individual, upon application for medical assistance, shall be presumed eligible for such assistance for a period of sixty days from the date of transfer from a general hospital, as defined in section twenty-eight hundred one of the public health law to a certified home health agency [or long term home health care program], as defined in section thirty-six hundred two of the public health law, or to a hospice as defined in section four thousand two of the public health law, or to a residential health care facility as defined in section twenty-eight hundred one of the public health law, if the local department of social services determines that the applicant meets each of the following criteria: (a) the applicant is receiving acute care in such hospital; (b) a physician certifies that such applicant no longer requires acute hospital care, but still requires medical care which can be provided by a certified home health agency, [long term home health care program,] hospice or residential health care facility; (c) the applicant or his OR HER representative states that the applicant does not have insurance coverage for the required medical care and that such care cannot be afforded; (d) it reasonably appears that the applicant is otherwise

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

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eligible to receive medical assistance; (e) it reasonably appears that the amount expended by the state and the local social services district for medical assistance in a certified home health agency, [long term home health care program,] hospice or residential health care facility, during the period of presumed eligibility, would be less than the amount the state and the local social services district would expend for continued acute hospital care for such person; and (f) such other determinative criteria as the commissioner shall provide by rule or regulation. If a person has been determined to be presumptively eligible for medical assistance, pursuant to this subdivision, and is subsequently determined to be ineligible for such assistance, the commissioner, on behalf of the state and the local social services district shall have the authority to recoup from the individual the sums expended for such assistance during the period of presumed eligibility.

2. Payment for up to sixty days of care for services provided under the medical assistance program shall be made for an applicant presumed eligible for medical assistance pursuant to subdivision one of this section provided, however, that such payment shall not exceed sixty-five percent of the rate payable under this title for services provided by a certified home health agency, [long term home health care program,] hospice or residential health care facility. Notwithstanding any other provision of law, no federal financial participation shall be claimed for services provided to a person while presumed eligible for medical assistance under this program until such person has been determined to be eligible for medical assistance by the local social services district. During the period of presumed medical assistance eligibility, payment for services provided persons presumed eligible under this program shall be made from state funds. Upon the final determination of eligibility by the local social services district, payment shall be made for the balance of the cost of such care and services provided to such applicant for such period of eligibility and a retroactive adjustment shall be made by the department to appropriately reflect federal financial participation and the local share of costs for the services provided during the period of presumptive eligibility. Such federal and local financial participation shall be the same as that which would have occurred if a final determination of eligibility for medical assistance had been made prior to the provision of the services provided during the period of presumptive eligibility. In instances where an individual who is presumed eligible for medical assistance is subsequently determined to be ineligible, the cost for services provided to such individual shall be reimbursed in accordance with the provisions of section three hundred sixty-eight-a of this [article] TITLE. Provided, however, if upon audit the department determines that there are subsequent determinations of ineligibility for medical assistance in at least fifteen percent of the cases in which presumptive eligibility has been granted in a local social services district, payments for services provided to all persons presumed eligible and subsequently determined ineligible for medical assistance shall be divided equally by the state and the district.

S 2. Subdivisions 1 and 2 of section 364-i of the social services law, as added by chapter 626 of the laws of 1987, are amended to read as follows:

1. An individual, upon application for medical assistance, shall be presumed eligible for such assistance for a period of sixty days from the date of transfer from a general hospital, as defined in section twenty-eight hundred one of the public health law to a certified home

health agency [or long term home health care program], as defined in section thirty-six hundred two of the public health law, if the local department of social services determines that the applicant meets each of the following criteria: (a) the applicant is receiving acute care in such hospital; (b) a physician certifies that such applicant no longer requires acute hospital care, but still requires medical care which can be provided by a certified home health agency [or a long term home health care program]; (c) the applicant or his OR HER representative states that the applicant does not have insurance coverage for the required medical care and that such care cannot be afforded; (d) it reasonably appears that the applicant is otherwise eligible to receive medical assistance; (e) it reasonably appears that the amount expended by the state and the local social services district for medical assistance in a certified home health agency [or long term home health care program], during the period of presumed eligibility, would be less than the amount the state and the local social services district would expend for continued acute hospital care for such person; and (f) such other determinative criteria as the commissioner shall provide by rule or regulation. If a person has been determined to be presumptively eligible for medical assistance, pursuant to this subdivision, and is subsequently determined to be ineligible for such assistance, the commissioner, on behalf of the state and the local social services district shall have the authority to recoup from the individual the sums expended for such assistance during the period of presumed eligibility.

2. Payment for up to sixty days of care for services provided under the medical assistance program shall be made for an applicant presumed eligible for medical assistance pursuant to subdivision one of this section provided, however, that such payment shall not exceed sixty-five percent of the rate payable under this title for services provided by a certified home health agency [or a long term home health care program]. Notwithstanding any other provision of law, no federal financial participation shall be claimed for services provided to a person while presumed eligible for medical assistance under this program until such person has been determined to be eligible for medical assistance by the local social services district. During the period of presumed medical assistance eligibility, payment for services provided persons presumed eligible under this program shall be made from state funds. Upon the final determination of eligibility by the local social services district, payment shall be made for the balance of the cost of such care and services provided to such applicant for such period of eligibility and a retroactive adjustment shall be made by the department to appropriately reflect federal financial participation and the local share of costs for the services provided during the period of presumptive eligibility. Such federal and local financial participation shall be the same as that which would have occurred if a final determination of eligibility for medical assistance had been made prior to the provision of the services provided during the period of presumptive eligibility. In instances where an individual who is presumed eligible for medical assistance is subsequently determined to be ineligible, the cost for services provided to such individual shall be reimbursed in accordance with the provisions of section three hundred sixty-eight-a of this [article] TITLE. Provided, however, if upon audit the department determines that there are subsequent determinations of ineligibility for medical assistance in at least fifteen percent of the cases in which presumptive eligibility has been granted in a local social services district, payments for services provided to all persons presumed eligi-

ble and subsequently determined ineligible for medical assistance shall be divided equally by the state and the district.

S 3. Paragraph (d) of subdivision 2 of section 365-f of the social services law, as added by chapter 81 of the laws of 1995, is amended to read as follows:

(d) meets such other criteria, as may be established by the commissioner, which are necessary to effectively implement the objectives of this section. SUCH CRITERIA SHALL INCLUDE, BUT NOT BE LIMITED TO, A REQUIREMENT THAT ANY PERSON WHO IS ELIGIBLE FOR, OR REASONABLY APPEARS TO MEET THE CRITERIA OF ELIGIBILITY FOR, BENEFITS UNDER SUBCHAPTER XVIII OF THE FEDERAL SOCIAL SECURITY ACT SHALL BE REQUIRED TO APPLY FOR AND FULLY UTILIZE SUCH BENEFITS IN ACCORDANCE WITH THIS CHAPTER TO DEFRAY THE COSTS OF THE PROGRAM. IF SUCH PERSON APPLIES FOR SUCH BENEFITS UNDER SUBCHAPTER XVIII OF THE FEDERAL SOCIAL SECURITY ACT AND SUCH PERSON'S APPLICATION THEREFOR IS DENIED, SUCH PERSON MUST APPEAL SUCH DENIAL OR PERMIT THE LOCAL SOCIAL SERVICES OFFICIAL TO DO SO ON HIS OR HER BEHALF. IF SUCH PERSON RECEIVES SUCH BENEFITS UNDER SUBCHAPTER XVIII OF THE FEDERAL SOCIAL SECURITY ACT AND SUCH PERSON'S CONTINUING RECEIPT THEREOF IS TERMINATED, SUCH PERSON MUST APPEAL SUCH TERMINATION OR PERMIT THE LOCAL SOCIAL SERVICES OFFICIAL TO DO SO ON HIS OR HER BEHALF.

S 4. Subparagraph 1 of paragraph (b) of subdivision 2 of section 366 of the social services law, as amended by chapter 638 of the laws of 1993 and designated by chapter 170 of the laws of 1994, is amended to read as follows:

(1) In establishing standards for determining eligibility for and amount of such assistance, the department shall take into account only such income and resources, in accordance with federal requirements, as are available to the applicant or recipient and as would not be required to be disregarded or set aside for future needs, and there shall be a reasonable evaluation of any such income or resources. The department shall not consider the availability of an option for an accelerated payment of death benefits or special surrender value pursuant to paragraph one of subsection (a) of section one thousand one hundred thirteen of the insurance law, or an option to enter into a viatical settlement pursuant to the provisions of article seventy-eight of the insurance law, as an available resource in determining eligibility for an amount of such assistance, provided, however, that the payment of such benefits shall be considered in determining eligibility for and amount of such assistance. There shall not be taken into consideration the financial responsibility of any individual for any applicant or recipient of assistance under this title unless such applicant or recipient is such individual's spouse or such individual's child who is under twenty-one years of age. In determining the eligibility of a child who is categorically eligible as blind or disabled, as determined under regulations prescribed by the social security act for medical assistance, the income and resources of parents or spouses of parents are not considered available to that child if [she/he] HE OR SHE does not regularly share the common household even if the child returns to the common household for periodic visits. In the application of standards of eligibility with respect to income, costs incurred for medical care, whether in the form of insurance premiums or otherwise, shall be taken into account. Any person who is eligible for, or reasonably appears to meet the criteria of eligibility for, benefits under [title] SUBCHAPTER XVIII of the federal social security act shall be required to apply for and fully utilize such benefits in accordance with this chapter. IN THE CASE OF A PERSON WHO IS RECEIVING OR SEEKING LONG TERM CARE, BENEFITS UNDER

SUBCHAPTER XVIII OF THE FEDERAL SOCIAL SECURITY ACT SHALL BE FULLY UTILIZED IN ACCORDANCE WITH THIS CHAPTER TO DEFRAY THE COSTS OF SUCH LONG TERM CARE. IF SUCH PERSON APPLIES FOR SUCH BENEFITS UNDER SUBCHAPTER XVIII OF THE FEDERAL SOCIAL SECURITY ACT AND SUCH PERSON'S APPLICATION THEREFOR IS DENIED, SUCH PERSON MUST APPEAL SUCH DENIAL OR PERMIT THE LOCAL SOCIAL SERVICES OFFICIAL TO DO SO ON HIS OR HER BEHALF. IF SUCH PERSON RECEIVES SUCH BENEFITS UNDER SUBCHAPTER XVIII OF THE FEDERAL SOCIAL SECURITY ACT AND SUCH PERSON'S CONTINUING RECEIPT THEREOF IS TERMINATED, SUCH PERSON MUST APPEAL SUCH TERMINATION OR PERMIT THE LOCAL SOCIAL SERVICES OFFICIAL TO DO SO ON HIS OR HER BEHALF.

S 5. Subparagraph (v) of paragraph b of subdivision 6-a of section 366 of the social services law, as amended by chapter 627 of the laws of 2004, is amended to read as follows:

(v) meet such other criteria as may be established by the commissioner of health as may be necessary to administer the provision of this subdivision in an equitable manner. SUCH CRITERIA SHALL INCLUDE, BUT NOT BE LIMITED TO, A REQUIREMENT THAT ANY PERSON WHO IS ELIGIBLE FOR, OR REASONABLY APPEARS TO MEET THE CRITERIA OF ELIGIBILITY FOR, BENEFITS UNDER SUBCHAPTER XVIII OF THE FEDERAL SOCIAL SECURITY ACT SHALL BE REQUIRED TO APPLY FOR AND FULLY UTILIZE SUCH BENEFITS IN ACCORDANCE WITH THIS CHAPTER TO DEFRAY THE COSTS OF THE PROGRAM. IF SUCH PERSON APPLIES FOR SUCH BENEFITS UNDER SUBCHAPTER XVIII OF THE FEDERAL SOCIAL SECURITY ACT AND SUCH PERSON'S APPLICATION THEREFOR IS DENIED, SUCH PERSON MUST APPEAL SUCH DENIAL OR PERMIT THE LOCAL SOCIAL SERVICES OFFICIAL TO DO SO ON HIS OR HER BEHALF. IF SUCH PERSON RECEIVES SUCH BENEFITS UNDER SUBCHAPTER XVIII OF THE FEDERAL SOCIAL SECURITY ACT AND SUCH PERSON'S CONTINUING RECEIPT THEREOF IS TERMINATED, SUCH PERSON MUST APPEAL SUCH TERMINATION OR PERMIT THE LOCAL SOCIAL SERVICES OFFICIAL TO DO SO ON HIS OR HER BEHALF.

S 6. Subparagraph (viii) of paragraph b of subdivision 9 of section 366 of the social services law, as added by chapter 170 of the laws of 1994, is amended to read as follows:

(viii) meet such other criteria as may be established by the commissioner of mental health, in conjunction with the commissioner, as may be necessary to administer the provisions of this subdivision in an equitable manner, including those criteria established pursuant to paragraph e of this subdivision. SUCH CRITERIA SHALL INCLUDE, BUT NOT BE LIMITED TO, A REQUIREMENT THAT ANY PERSON WHO IS ELIGIBLE FOR, OR REASONABLY APPEARS TO MEET THE CRITERIA OF ELIGIBILITY FOR, BENEFITS UNDER SUBCHAPTER XVIII OF THE FEDERAL SOCIAL SECURITY ACT SHALL BE REQUIRED TO APPLY FOR AND FULLY UTILIZE SUCH BENEFITS IN ACCORDANCE WITH THIS CHAPTER TO DEFRAY THE COSTS OF THE PROGRAM. IF SUCH PERSON APPLIES FOR SUCH BENEFITS UNDER SUBCHAPTER XVIII OF THE FEDERAL SOCIAL SECURITY ACT AND SUCH PERSON'S APPLICATION THEREFOR IS DENIED, SUCH PERSON MUST APPEAL SUCH DENIAL OR PERMIT THE LOCAL SOCIAL SERVICES OFFICIAL TO DO SO ON HIS OR HER BEHALF. IF SUCH PERSON RECEIVES SUCH BENEFITS UNDER SUBCHAPTER XVIII OF THE FEDERAL SOCIAL SECURITY ACT AND SUCH PERSON'S CONTINUING RECEIPT THEREOF IS TERMINATED, SUCH PERSON MUST APPEAL SUCH TERMINATION OR PERMIT THE LOCAL SOCIAL SERVICES OFFICIAL TO DO SO ON HIS OR HER BEHALF.

S 7. The social services law is amended by adding a new section 366-i to read as follows:

S 366-I. LONG TERM CARE; OTHER CASES. IN ALL CASES NOT OTHERWISE PROVIDED FOR IN THIS TITLE OF A PERSON WHO IS RECEIVING OR SEEKING LONG TERM CARE, BENEFITS UNDER SUBCHAPTER XVIII OF THE FEDERAL SOCIAL SECURITY ACT SHALL BE FULLY UTILIZED IN ACCORDANCE WITH THIS CHAPTER TO DEFRAY THE COSTS OF SUCH LONG TERM CARE. IF SUCH PERSON APPLIES FOR SUCH BENE-

FITS UNDER SUBCHAPTER XVIII OF THE FEDERAL SOCIAL SECURITY ACT AND SUCH PERSON'S APPLICATION THEREFOR IS DENIED, SUCH PERSON MUST APPEAL SUCH DENIAL OR PERMIT THE LOCAL SOCIAL SERVICES OFFICIAL TO DO SO ON HIS OR HER BEHALF. IF SUCH PERSON RECEIVES SUCH BENEFITS UNDER SUBCHAPTER XVIII OF THE FEDERAL SOCIAL SECURITY ACT AND SUCH PERSON'S CONTINUING RECEIPT THEREOF IS TERMINATED, SUCH PERSON MUST APPEAL SUCH TERMINATION OR PERMIT THE LOCAL SOCIAL SERVICES OFFICIAL TO DO SO ON HIS OR HER BEHALF.

S 8. Subdivision 3 of section 367-a of the social services law is amended by adding a new paragraph (e) to read as follows:

(E) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS SECTION OR OF ANY OTHER LAW, FOR ANY PERSON WHO IS ELIGIBLE FOR MEDICAL ASSISTANCE AND FOR MEDICARE UNDER SUBCHAPTER XVIII OF THE FEDERAL SOCIAL SECURITY ACT, THE COST OF THE PREMIUM FOR MEDICARE PART A SHALL BE BORNE BY THE STATE.

S 9. Subdivision 7 of section 367-c of the social services law, as added by chapter 895 of the laws of 1977 and renumbered by chapter 854 of the laws of 1987, is amended to read as follows:

7. No social services district shall make payments pursuant to [title] SUBCHAPTER XIX of the federal Social Security Act for benefits available under [title] SUBCHAPTER XVIII of such act without documentation that [title] SUBCHAPTER XVIII claims have been filed and denied. UPON SUCH DENIAL, SUCH PERSON MUST APPEAL SUCH DENIAL OR PERMIT THE LOCAL SOCIAL SERVICES OFFICIAL TO DO SO ON HIS OR HER BEHALF. IF SUCH PERSON RECEIVES SUCH BENEFITS UNDER SUBCHAPTER XVIII OF THE FEDERAL SOCIAL SECURITY ACT AND SUCH PERSON'S CONTINUING RECEIPT THEREOF IS TERMINATED, SUCH PERSON MUST APPEAL SUCH TERMINATION OR PERMIT THE LOCAL SOCIAL SERVICES OFFICIAL TO DO SO ON HIS OR HER BEHALF.

S 10. Subdivision 3 of section 367-e of the social services law, as added by chapter 622 of the laws of 1988, is amended to read as follows:

3. The commissioner shall apply for any waivers, including home and community based services waivers pursuant to section nineteen hundred fifteen-c of the social security act, necessary to implement AIDS home care programs. Notwithstanding any inconsistent provision of law but subject to expenditure limitations of this section, the commissioner, subject to the approval of the state director of the budget, may authorize the utilization of medical assistance funds to pay for services provided by AIDS home care programs in addition to those services included in the medical assistance program under section three hundred sixty-five-a of this [chapter] TITLE, so long as federal financial participation is available for such services. Expenditures made under this subdivision shall be deemed payments for medical assistance for needy persons and shall be subject to reimbursement by the state in accordance with the provisions of section three hundred sixty-eight-a of this [chapter] TITLE. ANY PERSON WHO IS ELIGIBLE FOR, OR REASONABLY APPEARS TO MEET THE CRITERIA OF ELIGIBILITY FOR, BENEFITS UNDER SUBCHAPTER XVIII OF THE FEDERAL SOCIAL SECURITY ACT SHALL BE REQUIRED TO APPLY FOR AND FULLY UTILIZE SUCH BENEFITS IN ACCORDANCE WITH THIS CHAPTER TO DEFRAY THE COSTS OF THE PROGRAM. IF SUCH PERSON APPLIES FOR SUCH BENEFITS UNDER SUBCHAPTER XVIII OF THE FEDERAL SOCIAL SECURITY ACT AND SUCH PERSON'S APPLICATION THEREFOR IS DENIED, SUCH PERSON MUST APPEAL SUCH DENIAL OR PERMIT THE LOCAL SOCIAL SERVICES OFFICIAL TO DO SO ON HIS OR HER BEHALF. IF SUCH PERSON RECEIVES SUCH BENEFITS UNDER SUBCHAPTER XVIII OF THE FEDERAL SOCIAL SECURITY ACT AND SUCH PERSON'S CONTINUING RECEIPT THEREOF IS TERMINATED, SUCH PERSON MUST APPEAL SUCH TERMINATION OR PERMIT THE LOCAL SOCIAL SERVICES OFFICIAL TO DO SO ON HIS OR HER BEHALF.

S 11. Subdivision 2 of section 367-f of the social services law, as added by chapter 659 of the laws of 1997, is amended to read as follows:

2. Notwithstanding any inconsistent provision of this chapter or any other law to the contrary, the partnership for long term care program shall provide Medicaid extended coverage to a person receiving long term care services if there is federal participation pursuant to such treatment and such person: (a) is or was covered by an insurance policy or certificate providing coverage for long term care which meets the applicable minimum benefit standards of the superintendent of insurance and other requirements for approval of participation under the program; and, (b) has exhausted the coverage and benefits as required by the program. ANY SUCH PERSON WHO IS RECEIVING MEDICAL ASSISTANCE AND WHO IS ELIGIBLE FOR, OR REASONABLY APPEARS TO MEET THE CRITERIA OF ELIGIBILITY FOR, BENEFITS UNDER SUBCHAPTER XVIII OF THE FEDERAL SOCIAL SECURITY ACT SHALL BE REQUIRED TO APPLY FOR AND FULLY UTILIZE SUCH BENEFITS IN ACCORDANCE WITH THIS CHAPTER TO DEFRAY THE COSTS OF THE PROGRAM. IF SUCH PERSON APPLIES FOR SUCH BENEFITS UNDER SUBCHAPTER XVIII OF THE FEDERAL SOCIAL SECURITY ACT AND SUCH PERSON'S APPLICATION THEREFOR IS DENIED, SUCH PERSON MUST APPEAL SUCH DENIAL OR PERMIT THE LOCAL SOCIAL SERVICES OFFICIAL TO DO SO ON HIS OR HER BEHALF. IF SUCH PERSON RECEIVES SUCH BENEFITS UNDER SUBCHAPTER XVIII OF THE FEDERAL SOCIAL SECURITY ACT AND SUCH PERSON'S CONTINUING RECEIPT THEREOF IS TERMINATED, SUCH PERSON MUST APPEAL SUCH TERMINATION OR PERMIT THE LOCAL SOCIAL SERVICES OFFICIAL TO DO SO ON HIS OR HER BEHALF.

S 12. This act shall take effect on the one hundred twentieth day after it shall have become a law; provided that the commissioner of health is authorized to promulgate any and all rules and regulations and take any other measures necessary to implement this act on its effective date on or before such date; and provided further that the amendments to subdivisions 1 and 2 of section 364-i of the social services law made by section one of this act shall be subject to the expiration and reversion of such section pursuant to section 2 of chapter 693 of the laws of 1996, as amended, when upon such date the provisions of section two of this act shall take effect.