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

5227

2013-2014 Regular Sessions

I N A S S E M B L Y

February 21, 2013

Introduced by M. of A. BRENNAN, DINOWITZ, GOTTFRIED, ORTIZ, RIVERA, PEOPLES-STOKES, CASTRO, CAHILL, JAFFEE -- Multi-Sponsored by -- M. of A. GALEF, JACOBS, LUPARDO, SWEENEY -- read once and referred to the Committee on Social Services

AN ACT to amend the social services law, in relation to the medical assistance presumptive eligibility program

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

Section 1. Subdivisions 1, 2 and 3 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. (A) 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)] (I) the applicant is receiving acute care in such hospital; [(b)] (II) 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)] (III) the applicant or his representative states that the applicant does not have insurance coverage for the required medical care and that such care cannot be afforded; [(d)] (IV) it reasonably appears that the applicant is otherwise eligible to receive medical assistance; [(e)] (V) it reasonably appears that the amount expended by the state and the local

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

LBD03988-01-3

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)] (VI) such other determinative criteria as the commissioner OF HEALTH 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 OF HEALTH, 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.

(B) AN INDIVIDUAL, UPON APPLICATION FOR MEDICAL ASSISTANCE, SHALL BE PRESUMED ELIGIBLE FOR SUCH ASSISTANCE FOR CARE, SERVICES AND SUPPLIES RELATED TO THE TREATMENT OF A MENTAL ILLNESS FOR A PERIOD OF NINETY DAYS FROM THE DATE OF DISCHARGE FROM A HOSPITAL, AS DEFINED IN SECTION 1.03 OF THE MENTAL HYGIENE LAW, A CORRECTIONAL FACILITY AS DEFINED IN PARAGRAPH (A) OF SUBDIVISION FOUR OF SECTION TWO OF THE CORRECTION LAW OR A LOCAL CORRECTIONAL FACILITY AS DEFINED IN PARAGRAPH (A) OF SUBDIVISION SIXTEEN OF SECTION TWO OF THE CORRECTION LAW, IF THE LOCAL DEPARTMENT OF SOCIAL SERVICES DETERMINES THAT THE APPLICANT MEETS EACH OF THE FOLLOWING CRITERIA: (I) THE APPLICANT IS SEVERELY AND PERSISTENTLY MENTALLY ILL; (II) A PHYSICIAN CERTIFIES THAT SUCH APPLICANT REQUIRES MEDICAL CARE TO TREAT SUCH MENTAL ILLNESS; (III) THE APPLICANT OR HIS REPRESENTATIVE STATES THAT THE APPLICANT DOES NOT HAVE INSURANCE COVERAGE FOR THE REQUIRED MEDICAL CARE AND THAT SUCH CARE CANNOT BE AFFORDED; (IV) IT REASONABLY APPEARS THAT THE APPLICANT IS OTHERWISE ELIGIBLE TO RECEIVE MEDICAL ASSISTANCE; (V) IT REASONABLY APPEARS THAT THE AMOUNT EXPENDED BY THE STATE AND THE LOCAL SOCIAL SERVICES DISTRICT FOR MEDICAL ASSISTANCE FOR TREATMENT OF A MENTAL ILLNESS DURING THE PERIOD OF PRESUMED ELIGIBILITY, WOULD BE LESS THAN THE AMOUNT THE STATE AND THE LOCAL SOCIAL SERVICES DISTRICT WOULD EXPEND FOR CONTINUED OR FUTURE ACUTE HOSPITAL CARE FOR SUCH PERSON; AND (VI) SUCH OTHER DETERMINATIVE CRITERIA AS THE COMMISSIONER OF HEALTH 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 OF HEALTH, 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. (A) 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 PARAGRAPH (A) OF 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.

(B) PAYMENT FOR UP TO NINETY DAYS OF CARE FOR SERVICES PROVIDED UNDER THE MEDICAL ASSISTANCE PROGRAM SHALL BE MADE FOR AN APPLICANT PRESUMED ELIGIBLE FOR MEDICAL ASSISTANCE FOR CARE, SERVICES AND SUPPLIES RELATED TO THE TREATMENT OF A MENTAL ILLNESS PURSUANT TO PARAGRAPH (B) OF SUBDIVISION ONE OF THIS SECTION, PROVIDED HOWEVER, THAT SUCH PAYMENT SHALL NOT EXCEED ONE HUNDRED PERCENT OF THE RATE PAYABLE UNDER THIS TITLE FOR SUCH CARE, SERVICES AND SUPPLIES.

(C) 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] (I) IN THE CASE OF COSTS INCURRED FOR A PERSON PRESUMPTIVELY ELIGIBLE FOR MEDICAL ASSISTANCE UNDER PARAGRAPH (A) OF SUBDIVISION ONE OF THIS SECTION, 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 OF HEALTH 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 OF HEALTH 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.

(II) IN THE CASE OF COSTS INCURRED FOR A PERSON PRESUMPTIVELY ELIGIBLE FOR MEDICAL ASSISTANCE UNDER PARAGRAPH (B) OF SUBDIVISION ONE OF THIS SECTION 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 OF HEALTH TO APPROPRIATELY REFLECT FEDERAL FINANCIAL PARTICIPATION AND THE LOCAL SHARE OF COSTS FOR THE SERVICES PROVIDED DURING THE PERIOD OF PRESUMPTIVE ELIGIBILITY. SUCH FEDERAL 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. THERE SHALL BE NO LOCAL SHARE IN THE COSTS OF SUCH ASSISTANCE DURING THE PRESUMPTIVE ELIGIBILITY PERIOD; PROVIDED HOWEVER THAT IF UPON AUDIT THE DEPARTMENT OF HEALTH 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 REIMBURSED IN ACCORDANCE WITH THE PROVISIONS OF SECTION THREE HUNDRED SIXTY-EIGHT-A OF THIS TITLE.

3. On or before March thirty-first, [nineteen hundred ninety-seven] TWO THOUSAND SIXTEEN, the department OF HEALTH shall submit to the governor and legislature an evaluation of the program, including the program's effects on access, quality and cost of care, and any recommendations for future modifications to improve the program.

S 2. Subdivision 1 of section 368-a of the social services law is amended by adding a new paragraph (aa) to read as follows:

(AA) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW, REIMBURSEMENT BY THE STATE FOR PAYMENTS MADE, WHETHER BY THE DEPARTMENT OF HEALTH ON BEHALF OF A LOCAL SOCIAL SERVICES DISTRICT PURSUANT TO SECTION THREE HUNDRED SIXTY-SEVEN-B OF THIS TITLE OR BY A LOCAL SOCIAL SERVICES DISTRICT DIRECTLY, FOR MEDICAL ASSISTANCE FURNISHED TO AN INDIVIDUAL PRESUMED ELIGIBLE FOR MEDICAL ASSISTANCE UNDER PARAGRAPH (B) OF SUBDIVISION ONE OF SECTION THREE HUNDRED SIXTY-FOUR-I OF THIS TITLE, DURING THE PRESUMPTIVE ELIGIBILITY PERIOD, SHALL BE MADE FOR THE FULL AMOUNT EXPENDED FOR SUCH ASSISTANCE, AFTER FIRST DEDUCTING THEREFROM ANY FEDERAL FUNDS PROPERLY RECEIVED OR TO BE RECEIVED ON ACCOUNT OF SUCH EXPENDITURE; PROVIDED THAT IF UPON AUDIT THE DEPARTMENT OF HEALTH 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 REIMBURSED IN ACCORDANCE WITH PARAGRAPH (D) OF THIS SUBDIVISION.

S 3. This act shall take effect April 1, 2015.