STATE OF NEW YORK

833--A

2021-2022 Regular Sessions

IN ASSEMBLY

(Prefiled)

January 6, 2021

Introduced by M. of A. GOTTFRIED, BARRON, CUSICK, CYMBROWITZ, DINOWITZ, ENGLEBRIGHT, GALEF, KIM, LUPARDO, McMAHON, OTIS, SEAWRIGHT, SIMON, THIELE, STECK, CARROLL, HEVESI, ABINANTI, GOODELL, COLTON, FORREST -- read once and referred to the Committee on Health -- reported and referred to the Committee on Ways and Means -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the social services law, in relation to the determination of eligibility for medical assistance benefits

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

Section 1. Clause (vi) of subparagraph 1 of paragraph (e) of subdivision 5 of section 366 of the social services law, as amended by section 13 of part MM of chapter 56 of the laws of 2020, is amended to read as follows:

(vi) "look-back period" means the sixty-month period immediately preceding the date that an institutionalized individual is both institutionalized and has applied for medical assistance, or in the case of a non-institutionalized individual, subject to federal approval, **for transfers made on or after October first, two thousand twenty,** the thirty-month period immediately preceding the date that such non-institutionalized individual applies for medical assistance coverage of long term care services. Nothing herein precludes a review of eligibility for retroactive authorization for medical expenses incurred during the three months prior to the month of application for medical assistance.

§ 2. Clauses (iii) and (iv) of subparagraph 4 of paragraph (e) of subdivision 5 of section 366 of the social services law, as added by section 26-a of part C of chapter 109 of the laws of 2006, are amended and a new clause (v) is added to read as follows:

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

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(iii) a satisfactory showing is made that: (A) the individual or the individual's spouse intended to dispose of the assets either at fair market value, or for other valuable consideration; or (B) the assets were transferred exclusively for a purpose other than to qualify for medical assistance; or (C) all assets transferred for less than fair market value have been returned to the individual **or used on the individual's behalf**; or

(iv) denial of eligibility would cause an undue hardship, such that application of the transfer of assets provision would deprive the individual of medical care such that the individual's health or life would be endangered, or would deprive the individual of food, clothing, shelter, or other necessities of life. The commissioner of health shall develop a hardship waiver process which shall include a timely process for determining whether an undue hardship waiver will be granted and a timely process under which an adverse determination can be appealed. The commissioner of health shall provide notice of the hardship waiver process in writing to those individuals who are required to comply with the transfer of assets provision under this section. If such an individual is an institutionalized individual, the facility in which he or she is residing shall be permitted to file an undue hardship waiver application on behalf of such individual with the consent of the individual or the personal representative of the individual[~~.~~]**; or**

(v) the transfer was to a family member or informal caregiver before the current period of institutional status, or before the application for Medicaid for non-institutional long-term care services, and all the following conditions are met:

(A) the transfer is in exchange for care services the family member or informal caregiver provided to the client or the client's spouse;

(B) the client or the client's spouse had a documented need for the care services provided by the family member or informal caregiver;

(C) the fair market value of the asset transferred is comparable to the fair market value of the care services provided; and

(D) the time for which care services are claimed is reasonable based on the kind of services provided.

§ 3. Subparagraph 5 of paragraph (e) of subdivision 5 of section 366 of the social services law, as added by section 26-a of part C of chapter 109 of the laws of 2006, is amended to read as follows:

(5) Any transfer made by an individual or the individual's spouse under subparagraph three of this paragraph shall cause the person to be ineligible for services for a period equal to the total, cumulative uncompensated value of all assets transferred during or after the look-back period, divided by the average monthly costs of nursing facility services provided to a private patient for a given period of time at the time of application, as determined pursuant to the regulations of the department. For purposes of this subparagraph, the average monthly costs of nursing facility services to a private patient for a given period of time at the time of application shall be presumed to be one hundred twenty percent of the average medical assistance rate of payment as of the first day of January of each year for nursing facilities within the region where the applicant resides, as established pursuant to paragraph (b) of subdivision sixteen of section twenty-eight hundred seven-c of the public health law. The period of ineligibility shall begin the first day of a month during or after which assets have been transferred for less than fair market value, or**, (i) for institutionalized individuals,** the first day the otherwise eligible individual is receiving services for which medical assistance coverage would be available based on an

approved application for such care but for the provisions of subparagraph three of this paragraph, whichever is later, and which does not occur in any other periods of ineligibility under this paragraph**, or (ii) for non-institutionalized individuals, the first day the otherwise eligible individual is functionally eligible for services for which medical assistance would be available based on an approved application for such care but for the provisions of subparagraph three of this paragraph, whichever is later, and which does not occur in any other periods of ineligibility under this paragraph**.

§ 4. Subdivision 12 of section 366-a of the social services law, as added by section 36-c of part B of chapter 57 of the laws of 2015, is amended to read as follows:

12. The commissioner shall develop expedited procedures for determining medical assistance eligibility for any medical assistance applicant with an immediate need for personal care or consumer directed personal assistance services pursuant to paragraph (e) of subdivision two of section three hundred sixty-five-a of this title or section three hundred sixty-five-f of this title, respectively. Such procedures shall require that a final eligibility determination be made within seven days of the date of a [~~complete~~] medical assistance application **that shall be complete, except that a non-institutionalized individual applicant may attest that no transfers of assets were made within the look-back period under subdivision five of section three hundred sixty-six of this title; provided the non-institutionalized individual applicant shall submit complete documentation of assets during the look-back period within thirty days of the date the application was filed**.

§ 5. This act shall take effect immediately.