§ 364-i. Medical assistance presumptive eligibility program. 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 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, 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. 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.

3. On or before March thirty-first, nineteen hundred ninety-seven, the department 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.

4. Persons in need of treatment for breast, cervical, colon or prostate cancer; presumptive eligibility. (a) An individual shall be presumed to be eligible for medical assistance under this title beginning on the date that a qualified entity, as defined in paragraph (c) of this subdivision, determines, on the basis of preliminary information, that the individual meets the requirements of paragraph (d) or (e) of subdivision four of section three hundred sixty-six of this title.

(b) Such presumptive eligibility shall continue through the earlier of the day on which a determination is made with respect to the eligibility of such individual for services, or in the case of such an individual who does not file an application by the last day of the month following the month during which the qualified entity makes the determination of presumptive eligibility, such last day.

(c) For the purposes of this subdivision, "qualified entity" means an entity that provides medical assistance approved under this title, and is determined by the department of health to be capable of making determinations of presumptive eligibility under this subdivision.

(d) Care, services and supplies, as set forth in section three hundred sixty-five-a of this title, that are furnished to an individual during a presumptive eligibility period under this subdivision by an entity that is eligible for payments under this title shall be deemed to be medical assistance for purposes of payment and state reimbursement.

5. (a) A pregnant woman shall be presumed to be eligible for medical assistance under this title, excluding inpatient services and institutional long term care, beginning on the date that a prenatal care provider, licensed under article twenty-eight of the public health law or other prenatal care provider approved by the department of health determines, on the basis of preliminary information, that the pregnant woman's MAGI household income does not exceed the MAGI-equivalent of two hundred percent of the federal poverty line for the applicable family size.

(a-2) At the time of application for presumptive eligibility pursuant to this subdivision, a pregnant woman who resides in a social services district that has implemented the state's managed care program pursuant

to section three hundred sixty-four-j of this title must choose a managed care provider. If a managed care provider is not chosen at the time of application, the pregnant woman will be assigned to a managed care provider in accordance with subparagraphs (ii), (iii), (iv) and (v) of paragraph (f) of subdivision four of section three hundred sixty-four-j of this title.

(b) Such presumptive eligibility shall continue through the earlier of: the day on which eligibility is determined pursuant to this title; or the last day of the month following the month in which the provider makes preliminary determination, in the case of a pregnant woman who does not file an application for medical assistance on or before such day.

(c) The department of health shall provide prenatal care providers licensed under article twenty-eight of the public health law and other approved prenatal care providers with such forms as are necessary for a pregnant woman to apply and information on how to assist such women in completing and filing such forms. A qualified provider which determines that a pregnant woman is presumptively eligible shall notify the social services district in which the pregnant woman resides of the determination within five working days after the date on which such determination is made and shall inform the woman at the time the determination is made that she is required to make application by the last day of the month following the month in which the determination is made.

(d) Notwithstanding any other provision of law, care that is furnished to a pregnant woman pursuant to this subdivision during a presumptive eligibility period shall be deemed as medical assistance for purposes of payment and state reimbursement.

(e) Facilities licensed under article twenty-eight of the public health law providing prenatal care services shall perform presumptive eligibility determinations and assist women in submitting appropriate documentation to the social services district as required by the commissioner; provided, however, that a facility may apply to the commissioner for exemption from this requirement on the basis of undue hardship.

(f) All prenatal care providers enrolled in the medicaid program must provide prenatal care services to eligible service recipients determined

presumptively eligible for medical assistance but not yet enrolled in the medical assistance program, and assist women in submitting appropriate documentation to the social services district as required by the commissioner.

6. Notwithstanding any other section of law, where care, services, or supplies are received prior to the date an individual is determined eligible for assistance under this title, medical assistance reimbursement, regardless of funding source, shall be available for such care, services, or supplies only (a) if the care, services, or supplies are received during the three month period preceding the month of application for medical assistance and the recipient is determined to have been eligible in the month in which the care, service, or supply was received, or (b) if provided during a period of presumptive eligibility pursuant to this section.

7. (a) The following individuals shall be presumed to be eligible for medical assistance under this title beginning on the date that a qualified hospital, as defined in paragraph (b) of this subdivision, determines, on the basis of preliminary information, that:

(1) a child has MAGI household income that does not exceed the applicable level for eligibility as provided for pursuant to subparagraph two or three of paragraph (b) of subdivision one of section three hundred sixty-six of this title;

(2) a pregnant woman has MAGI household income that does not exceed the MAGI-equivalent of two hundred percent of the federal poverty line for the applicable family size;

(3) a parent or caretaker relative has MAGI household income that does not exceed the MAGI-equivalent of one hundred thirty percent of the highest amount that ordinarily would have been paid to a person without any income or resources under the family assistance program as it existed on the first day of November, nineteen hundred ninety-seven, or has net available income, including available support from responsible relatives, that does not exceed the amounts set forth in paragraph (a) of subdivision two of section three hundred sixty-six of this title;

(4) an individual in need of treatment of breast, cervical, colon, or prostate cancer meets the requirements of paragraph (d) or (e) of

subdivision four of section three hundred sixty-six of this title;

(5) an individual age nineteen or older and under age sixty-five meets the requirements of subparagraph one of paragraph (b) of subdivision one of section three hundred sixty-six of this title;

(6) an individual under twenty-six years of age meets the requirements of subparagraph nine of paragraph (c) of subdivision one of section three hundred sixty-six of this title; and

(7) an individual has income that does not exceed the MAGI-equivalent of two hundred percent of the federal poverty line for the applicable family size, and the individual meets the requirements of subparagraph six of paragraph (b) of subdivision one of section three hundred sixty-six of this title; coverage pursuant to this subparagraph shall be limited to family planning services reimbursed by the federal government at a rate of ninety percent.

(b) For the purposes of this subdivision, "qualified hospital" means a hospital that:

(1) is licensed as a general hospital under article twenty-eight of the public health law;

(2) is enrolled as a provider in the program of medical assistance under this title;

(3) has notified the department of health of its election to make presumptive eligibility determinations under this subdivision, and agrees to make such determinations in accordance with policies and procedures established by the department;

(4) has been designated by the department of health as a certified application counselor to provide information to individuals concerning qualified health plans offered through a health insurance exchange and other insurance affordability programs, assist individuals to apply for coverage through a qualified health plan or insurance affordability program, and help facilitate the enrollment of eligible individuals in such plans or programs; and

(5) has not been disqualified by the department of health pursuant to paragraph (c) of this subdivision.

(c) The department of health may disqualify a hospital as a qualified hospital if the department determines that the hospital is not:

(1) making, or is not capable of making, presumptive eligibility determinations in accordance with the policies and procedures

established by the department; or

(2) meeting such standards as may be established by the department with respect to the proportion of individuals determined presumptively eligible by the hospital who are found by the medical assistance program to be eligible for ongoing medical assistance after the end of the presumptive eligibility period.

(d) Care, services and supplies, as set forth in section three hundred sixty-five-a of this title, that are furnished to an individual during a presumptive eligibility period under this subdivision by an entity that is eligible for payments under this title shall be deemed to be medical assistance for purposes of payment and state reimbursement.