NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

A Guide to the Written Test

for the

Medicaid Series

Including examinations for:

Medicaid Eligibility Examiner

Medicaid Redesign Analyst

Medical Assistance Specialist

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Governor

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Acting Commissioner

STUDY GUIDE
for
Medicaid Series

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SOS § 366. Eligibility

1. (a) Definitions. For purposes of this section:

(1) “benchmark coverage” refers to medical assistance coverage defined in subdivision one of section three hundred sixty-five-a of this title;

(2) “caretaker relative” means a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care and who is one of the following:
(i) the child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece; or
(ii) the spouse of such parent or relative, even after the marriage is terminated by death or divorce;

(3) “family size” means the number of persons counted as members of an individual's household; with respect to individuals whose medical assistance eligibility is based on modified adjusted gross income, in determining the family size of a pregnant woman, or of other individuals who have a pregnant woman in their household, the pregnant woman is counted as herself plus the number of children she is expected to deliver;

(4) “federal poverty line” means the poverty line defined and annually revised by the United States department of health and human services;

(5) “household”, for purposes of determining the financial eligibility of individuals whose medical assistance eligibility is based on modified adjusted gross income, shall mean:
(i) Basic rule for taxpayers not claimed as a tax dependent. In the case of an individual who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another taxpayer, the household consists of the taxpayer and, subject to clause (v) of this subparagraph, all persons whom such individual expects to claim as a tax dependent;
(ii) Basic rule for individuals claimed as a tax dependent. In the case of an individual who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the household is the household of the taxpayer claiming such individual as a tax dependent, except that the household must be determined in accordance with clause (iii) of this subparagraph in the case of:
(A) Individuals other than a spouse or child who expect to be claimed as a tax dependent by another taxpayer; and
(B) Individuals under nineteen years of age, or under twenty-one years of age if a full-time student, who expect to be claimed by one parent as a tax dependent and are living with both parents but whose parents do not expect to file a joint tax return; and
(C) Individuals under nineteen years of age, or under twenty-one years of age if a full-time student, who expect to be claimed as a tax dependent by a non-custodial parent. For purposes of this subclause:
(1) A court order or binding separation, divorce, or custody agreement establishing physical custody controls; or

(2) If there is no such order or agreement or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights;
(iii) Rules for individuals who neither file a tax return nor are claimed as a tax dependent. In the case of individuals who do not expect to file a Federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, or who are described in subclauses (A), (B), or (C) of clause (ii) of this subparagraph, the household consists of the individual and, if living with the individual:
(A) The individual's spouse;
(B) The individual's children under nineteen years of age, or under twenty-one years of age if a full-time student; and
(C) In the case of an individual under nineteen years of age, or under twenty-one years of age if a full-time student, the individual's parents and the individual's siblings under nineteen years of age, or under twenty-one years of age if a full-time student;
(iv) Married couples. In the case of a married couple living together, each spouse will be included in the household of the other spouse, regardless of whether they expect to file a joint tax return under section six thousand thirteen of the internal revenue code or whether one spouse expects to be claimed as a tax dependent by the other spouse.
(v) For purposes of clause (i) of this subparagraph, if a taxpayer cannot reasonably establish that another individual is a tax dependent of the taxpayer for the tax year in which Medicaid is sought, the inclusion of such individual in the household of the taxpayer is determined in accordance with clause (iii) of this subparagraph.

(6) “MAGI” means modified adjusted gross income;

(7) “MAGI-based income” means income calculated using the same methodologies used to determine MAGI under section 36B(d)(2)(B) of the Internal Revenue Code , 1 with the exception of lump sum payments, certain educational scholarships, and certain American Indian and Alaska Native income, as specified by the commissioner of health consistent with federal regulation at 42 CFR 435.603 or any successor regulation;

(8) “MAGI household income” means, with respect to an individual whose medical assistance eligibility is based on modified adjusted gross income, the sum of the MAGI-based income of every person included in the individual's MAGI household, except that it shall not include the MAGI-based income of the following persons if such persons are not expected to be required to file a tax return in the taxable year in which eligibility for medical assistance is being determined:
(i) a biological, adopted, or step child who is included in the individual's MAGI household; or
(ii) a person, other than a spouse or a biological, adopted, or step child, who is expected to be claimed as a tax dependent by the individual;

(9) “standard coverage” refers to medical assistance coverage defined in subdivision two of section three hundred sixty-five-a of this title.

(b) MAGI eligibility groups. Individuals listed in this paragraph are eligible for medical assistance based on modified adjusted gross income. In determining the eligibility of an individual for the MAGI eligibility group with the highest income standard under which the

individual may qualify, an amount equivalent to five percentage points of the federal poverty level for the applicable family size will be deducted from the household income.

(1) An individual is eligible for benchmark coverage if his or her MAGI household income does not exceed one hundred thirty-three percent of the federal poverty line for the applicable family size and he or she is:
(i) age nineteen or older and under age sixty-five; and
(ii) not pregnant; and
(iii) not entitled to or enrolled for benefits under parts A or B of title XVIII of the federal social security act; and
(iv) not otherwise eligible for and receiving coverage under subparagraphs two and three of this paragraph; and
(v) not a parent or other caretaker relative of a dependent child under twenty-one years of age and living with such child, unless such child is receiving benefits under this title or under title 1-A of article twenty-five of the public health law, or otherwise is enrolled in minimum essential coverage.

(2) A pregnant woman or an infant younger than one year of age is eligible for standard coverage if his or her MAGI household income does not exceed the MAGI-equivalent of two hundred percent of the federal poverty line for the applicable family size, which shall be calculated in accordance with guidance issued by the secretary of the United States department of health and human services, or an infant younger than one year of age who meets the presumptive eligibility requirements of subdivision four of section three hundred sixty-four-i of this title.

(3) A child who is at least one year of age but younger than nineteen years of age is eligible for standard coverage if his or her MAGI household income does not exceed the MAGI-equivalent of one hundred thirty-three percent of the federal poverty line for the applicable family size, which shall be calculated in accordance with guidance issued by the Secretary of the United States department of health and human services, or a child who is at least one year of age but younger than nineteen years of age who meets the presumptive eligibility requirements of subdivision four of section three hundred sixty-four-i of this title.

(4) An individual who is a pregnant woman or is a member of a family that contains a dependent child living with a parent or other caretaker relative is eligible for standard coverage if his or her MAGI household income 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, which shall be calculated in accordance with guidance issued by the Secretary of the United States department of health and human services; for purposes of this subparagraph, the term dependent child means a person who is under eighteen years of age, or is eighteen years of age and a full-time student, who is deprived of parental support or care by reason of the death, continued absence, or physical or mental incapacity of a parent, or by reason of the unemployment of the parent, as defined by the department of health.

(5) A child who is under twenty-one years of age and who was in foster care under the responsibility of the state on his or her eighteenth birthday is eligible for standard coverage; notwithstanding any provision of law to the contrary, the provisions of this subparagraph shall be effective only if and for so long as federal financial participation is available in the costs of medical assistance furnished hereunder.

(6) An individual who is not otherwise eligible for medical assistance under this section is eligible for coverage of family planning services reimbursed by the federal government at a rate of ninety percent, and for coverage of those services identified by the commissioner of health as services generally performed as part of or as a follow-up to a service eligible for such ninety percent reimbursement, including treatment for sexually transmitted diseases, if his or her income does not exceed the MAGI-equivalent of two hundred percent of the federal poverty line for the applicable family size, which shall be calculated in accordance with guidance issued by the secretary of the United States department of health and human services; provided further that the commissioner of health is authorized to establish criteria for presumptive eligibility for services provided pursuant to this subparagraph in accordance with all applicable requirements of federal law or regulation pertaining to such eligibility.

(7) [Expires and deemed repealed Oct. 1, 2019, pursuant to L.2013, c. 56, pt. D, § 76, subd. p.] A child who is nineteen or twenty years of age living with his or her parent will be eligible for standard coverage if the sum of the MAGI-based income of every person included in the child's MAGI household exceeds one hundred thirty-three percent, but does not exceed one hundred fifty percent, of the federal poverty line for the applicable family size.

(7-a) An individual is eligible for benchmark coverage if his or her MAGI household income exceeds one hundred thirty-three percent of the federal poverty line for the applicable family size and he or she:
(i) was eligible or would have been eligible for the family health plus program without federal financial participation in the costs of medical care and services under such program; and
(ii) is not eligible to enroll in a qualified health plan offered through the state health benefit exchange established pursuant to the federal Patient Protection and Affordable Care Act (P.L. 111-148), 2as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

(c) Non-MAGI eligibility groups. Individuals listed in this paragraph are eligible for standard coverage. Where a financial eligibility determination must be made by the medical assistance program for individuals in these groups, such financial eligibility will be determined in accordance with subdivision two of this section.

(1) An individual receiving or eligible to receive federal supplemental security income payments and/or additional state payments pursuant to title six of this article; any inconsistent provision of this chapter or other law notwithstanding, the department may designate the office of temporary and disability assistance as its agent to discharge its responsibility, or so much of its responsibility as is permitted by federal law, for determining eligibility for medical assistance with respect to persons who are not eligible to receive federal supplemental security income payments but who are receiving a state administered supplementary payment or mandatory

minimum supplement in accordance with the provisions of subdivision one of section two hundred twelve of this article.

(2) An individual who, although not receiving public assistance or care for his or her maintenance under other provisions of this chapter, has income and resources, including available support from responsible relatives, that does not exceed the amounts set forth in paragraph (a) of subdivision two of this section, and is (i) sixty-five years of age or older, or certified blind or certified disabled or (ii) for reasons other than income or resources, is eligible for federal supplemental security income benefits and/or additional state payments.

(3) An individual who, although not receiving public assistance or care for his or her maintenance under other provisions of this chapter, has income, including available support from responsible relatives, that does not exceed the amounts set forth in paragraph (a) of subdivision two of this section, and is (i) under the age of twenty-one years, or (ii) a spouse of a cash public assistance recipient living with him or her and essential or necessary to his or her welfare and whose needs are taken into account in determining the amount of his or her cash payment, or (iii) for reasons other than income, would meet the eligibility requirements of the aid to dependent children program as it existed on the sixteenth day of July, nineteen hundred ninety-six.

(4) A child in foster care, or a child described in section four hundred fifty-four or four hundred fifty-eight-d of this chapter.

(5) A disabled individual at least sixteen years of age, but under the age of sixty-five, who: would be eligible for benefits under the supplemental security income program but for earnings in excess of the allowable limit; has net available income that does not exceed two hundred fifty percent of the applicable federal income official poverty line, as defined and updated by the United States department of health and human services, for a one-person or two-person household, as defined by the commissioner in regulation; has household resources, as defined in paragraph (e) of subdivision two of section three hundred sixty-six-c of this title, other than retirement accounts, that do not exceed twenty thousand dollars for a one-person household or thirty thousand dollars for a two-person household, as defined by the commissioner in regulation; and contributes to the cost of medical assistance provided pursuant to this subparagraph in accordance with subdivision twelve of section three hundred sixty-seven-a of this title; for purposes of this subparagraph, disabled means having a medically determinable impairment of sufficient severity and duration to qualify for benefits under section 1902(a)(10)(A)(ii)(xv) of the social security act. 3

(6) An individual at least sixteen years of age, but under the age of sixty-five, who: is employed; ceases to be in receipt of medical assistance under subparagraph five of this paragraph because the person, by reason of medical improvement, is determined at the time of a regularly scheduled continuing disability review to no longer be eligible for supplemental security income program benefits or disability insurance benefits under the social security act; 4 continues to have a severe medically determinable impairment, to be determined in accordance with applicable federal regulations; and contributes to the cost of medical assistance provided pursuant to this subparagraph in accordance with subdivision twelve of section three hundred sixty-seven-a of this title; for purposes of this subparagraph, a person is

considered to be employed if the person is earning at least the applicable minimum wage under section six of the federal fair labor standards act 5 and working at least forty hours per month; or

(7) An individual receiving treatment for breast or cervical cancer who meets the eligibility requirements of paragraph (d) of subdivision four of this section or the presumptive eligibility requirements of subdivision five of section three hundred sixty-four-i of this title.

(8) An individual receiving treatment for colon or prostate cancer who meets the eligibility requirements of paragraph (e) of subdivision four of this section or the presumptive eligibility requirements of subdivision five of section three hundred sixty-four-i of this title.

(9) An individual who:
(i) is under twenty-six years of age; and
(ii) was in foster care under the responsibility of the state on his or her eighteenth birthday; and
(iii) was in receipt of medical assistance under this title while in foster care; and
(iv) is not otherwise eligible for medical assistance under this title.

(10) A resident of a home for adults operated by a social services district, or a residential care center for adults or community residence operated or certified by the office of mental health, and has not, according to criteria promulgated by the department consistent with this title, sufficient income, or in the case of a person sixty-five years of age or older, certified blind, or certified disabled, sufficient income and resources, including available support from responsible relatives, to meet all the costs of required medical care and services available under this title.

(d) Conditions of eligibility. A person shall not be eligible for medical assistance under this title unless he or she:

(1) is a resident of the state, or, while temporarily in the state, requires immediate medical care which is not otherwise available, provided that such person did not enter the state for the purpose of obtaining such medical care; and

(2) assigns to the appropriate social services official or to the department, in accordance with department regulations: (i) any benefits which are available to him or her individually from any third party for care or other medical benefits available under this title and which are otherwise assignable pursuant to a contract or any agreement with such third party; or (ii) any rights, of the individual or of any other person who is eligible for medical assistance under this title and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support specified as support for the purpose of medical care by a court or administrative order; and

(3) cooperates with the appropriate social services official or the department in establishing paternity or in establishing, modifying, or enforcing a support order with respect to his or her child; provided, however, that nothing herein contained shall be construed to require a payment under this title for care or services, the cost of which may be met in whole or in part by a third party; notwithstanding the foregoing, a social services official shall not require such

cooperation if the social services official or the department determines that such actions would be detrimental to the best interest of the child, applicant, or recipient, or with respect to pregnant women during pregnancy and during the sixty-day period beginning on the last day of pregnancy, in accordance with procedures and criteria established by regulations of the department consistent with federal law; and

(4) applies for and utilizes group health insurance benefits available through a current or former employer, including benefits for a spouse and dependent children, in accordance with the regulations of the department.

(e) Conditions of coverage. An otherwise eligible person shall not be entitled to medical assistance coverage of care, services, and supplies under this title while he or she:

(1) is an inmate or patient in an institution or facility wherein medical assistance may not be provided in accordance with applicable federal or state requirements, except for persons described in subparagraph ten of paragraph (c) of this subdivision or subdivision one-a or subdivision one-b of this section; or

(2) is a patient in a public institution operated primarily for the treatment of tuberculosis or care of the mentally disabled, with the exception of: (i) a person sixty-five years of age or older and a patient in any such institution; (ii) a person under twenty-one years of age and receiving in-patient psychiatric services in a public institution operated primarily for the care of the mentally disabled; (iii) a patient in a public institution operated primarily for the care of the mentally retarded who is receiving medical care or treatment in that part of such institution that has been approved pursuant to law as a hospital or nursing home; (iv) a patient in an institution operated by the state department of mental hygiene, while under care in a hospital on release from such institution for the purpose of receiving care in such hospital; or (v) is a person residing in a community residence or a residential care center for adults.

(f) Notwithstanding any inconsistent provision of this title, for an individual who has income in excess of an applicable income eligibility standard and is allowed to achieve eligibility for medical assistance under this title by incurring medical expenses equal to the amount of such excess income, the amount of excess income may be calculated by comparing the individual's MAGI household income to the MAGI-equivalent of the applicable income eligibility standard; provided, however, that medical assistance shall be furnished pursuant to this paragraph only if, for so long as, and to the extent that federal financial participation is available therefor. The commissioner of health shall make any amendments to the state plan for medical assistance, or apply for any waiver or approval under the federal social security act that are necessary to carry out the provisions of this paragraph.

(g) Coverage of certain noncitizens. (1) Applicants and recipients who are lawfully admitted for permanent residence, or who are permanently residing in the United States under color of law, or who are non-citizens in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) ; who are MAGI eligible pursuant to paragraph (b) of this subdivision; and who would be ineligible for medical assistance coverage under subdivisions one and two of section three hundred sixty-five-a of this title solely due to their immigration status if the provisions of section one hundred twenty-twoof this chapter were applied, shall only be eligible for assistance under this title if enrolled in a standard health plan offered by a basic health

program established pursuant to section three hundred sixty-nine-gg of this article if such program is established and operating.

(2) With respect to a person described in subparagraph one of this paragraph who is enrolled in a standard health plan, medical assistance coverage shall mean:
(i) payment of required premiums and other cost-sharing obligations under the standard health plan that exceed the person's co-payment obligation under subdivision six of section three hundred sixty-seven-a of this title; and
(ii) payment for services and supplies described in subdivision one or two of section three hundred sixty-five-a of this title, as applicable, but only to the extent that such services and supplies are not covered by the standard health plan.

(3) Nothing in this subdivision shall prevent a person described in subparagraph one of this paragraph from qualifying for or receiving medical assistance while his or her enrollment in a standard health plan is pending, in accordance with applicable provisions of this title.

1-a. Notwithstanding any other provision of law, in the event that a person who is an inmate of a state or local correctional facility, as defined in section two of the correction law , was in receipt of medical assistance pursuant to this title immediately prior to being admitted to such facility, such person shall remain eligible for medical assistance while an inmate, except that no medical assistance shall be furnished pursuant to this title for any care, services, or supplies provided during such time as the person is an inmate; provided, however, that nothing herein shall be deemed as preventing the provision of medical assistance for inpatient hospital services furnished to an inmate at a hospital outside of the premises of such correctional facility or pursuant to other federal authority authorizing the provision of medical assistance to an inmate of a state or local correctional facility during the thirty days prior to release, to the extent that federal financial participation is available for the costs of such services. Upon release from such facility, such person shall continue to be eligible for receipt of medical assistance furnished pursuant to this title until such time as the person is determined to no longer be eligible for receipt of such assistance. To the extent permitted by federal law, the time during which such person is an inmate shall not be included in any calculation of when the person must recertify his or her eligibility for medical assistance in accordance with this article. The state may seek federal authority to provide medical assistance for transitional services including but not limited to medical, prescription, and care coordination services for high needs inmates in state and local correctional facilities during the thirty days prior to release.

1-b. Notwithstanding any other provision of law, in the event that a person who is an inpatient in an institution for mental diseases, as defined by federal law and regulations, and who was in receipt of medical assistance pursuant to this title immediately prior to being admitted to such facility, or who was directly admitted to such facility after being an inpatient in another institution for mental diseases and who was in receipt of medical assistance prior to admission to such transferring institution, such person shall remain eligible for medical assistance while an inpatient in such facility; provided, however, that no medical assistance shall be furnished pursuant to this title for any care, services, or supplies provided during the time that such person is an inpatient, except to the extent that federal financial participation is available for

the costs of such care, services, or supplies. Upon release from such facility, such person shall continue to be eligible for receipt of medical assistance furnished pursuant to this title until such time as the person is determined to no longer be eligible for receipt of such assistance. To the extent permitted by federal law, the time during which such person is an inpatient in an institution for mental diseases shall not be included in any calculation of when the person must recertify his or her eligibility for medical assistance in accordance with this article.

2. (a) The following income and resources shall be exempt and shall not be taken into consideration in determining a person's eligibility for medical care, services and supplies available under this title:

(1)(i) for applications for medical assistance filed on or before December thirty-first, two thousand five, a homestead which is essential and appropriate to the needs of the household; (ii) for applications for medical assistance filed on or after January first, two thousand six, a homestead which is essential and appropriate to the needs of the household; provided, however, that in determining eligibility of an individual for medical assistance for nursing facility services and other long term care services, the individual shall not be eligible for such assistance if the individual's equity interest in the homestead exceeds seven hundred fifty thousand dollars; provided further, that the dollar amount specified in this clause shall be increased, beginning with the year two thousand eleven, from year to year, in an amount to be determined by the secretary of the federal department of health and human services, based on the percentage increase in the consumer price index for all urban consumers, rounded to the nearest one thousand dollars. If such secretary does not determine such an amount, the department of health shall increase such dollar amount based on such increase in the consumer price index. Nothing in this clause shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the homestead. The home equity limitation established by this clause shall be waived in the case of a demonstrated hardship, as determined pursuant to criteria established by such secretary. The home equity limitation shall not apply if one or more of the following persons is lawfully residing in the individual's homestead: (A) the spouse of the individual; or (B) the individual's child who is under the age of twenty-one, or is blind or permanently and totally disabled, as defined in section 1614 of the federal social security act.

(2) essential personal property;

(3) a burial fund, to the extent allowed as an exempt resource under the cash assistance program to which the applicant is most closely related;

(4) savings in amounts equal to one hundred fifty percent of the income amount permitted under subparagraph seven of this paragraph, provided, however, that the amounts for one and two person households shall not be less than the amounts permitted to be retained by households of the same size in order to qualify for benefits under the federal supplemental security income program;

(5)(i) such income as is disregarded or exempt under the cash assistance program to which the applicant is most closely related for purposes of this subparagraph, cash assistance

program means either the aid to dependent children program as it existed on the sixteenth day of July, nineteen hundred ninety-six, or the supplemental security income program; and
(ii) such income of a disabled person (as such term is defined in section 1614(a)(3) of the federal social security act (42 U.S.C. section 1382c(a)(3)) or in accordance with any other rules or regulations established by the social security administration), that is deposited in trusts as defined in clause (iii) of subparagraph two of paragraph (b) of this subdivision in the same calendar month within which said income is received;

(6) health insurance premiums;

(7) income based on the number of family members in the medical assistance household, as defined in regulations by the commissioner consistent with federal regulations under title XIX of the federal social security act 6and calculated as follows:
(i) The amounts for one and two person households and families shall be equal to twelve times the standard of monthly need for determining eligibility for and the amount of additional state payments for aged, blind and disabled persons pursuant to section two hundred nine of this article rounded up to the next highest one hundred dollars for eligible individuals and couples living alone, respectively.
(ii) The amounts for households of three or more shall be calculated by increasing the income standard for a household of two, established pursuant to clause (i) of this subparagraph, by fifteen percent for each additional household member above two, such that the income standard for a three-person household shall be one hundred fifteen percent of the income standard for a two-person household, the income standard for a four-person household shall be one hundred thirty percent of the income standard for a two-person household, and so on.
(iii) No other income or resources, including federal old-age, survivors and disability insurance, state disability insurance or other payroll deductions, whether mandatory or optional, shall be exempt and all other income and resources shall be taken into consideration and required to be applied toward the payment or partial payment of the cost of medical care and services available under this title, to the extent permitted by federal law.

(8) Redesignated (7).

(9) Subject to subparagraph eight 7, the department, upon the application of a local social services district, after passage of a resolution by the local legislative body authorizing such application, may adjust the income exemption based upon the variations between cost of shelter in urban areas and rural areas in accordance with standards prescribed by the United States secretary of health, education and welfare 8.

(10)(i) A person who is receiving or is eligible to receive federal supplemental security income payments and/or additional state payments is entitled to a personal needs allowance as follows:
(A) for the personal expenses of a resident of a residential health care facility, as defined by section twenty-eight hundred one of the public health law , the amount of fifty-five dollars per month;
(B) for the personal expenses of a resident of an intermediate care facility operated or licensed by the office of mental retardation and developmental disabilities or a patient of a

hospital operated by the office of mental health, as defined by subdivision ten of section 1.03 of the mental hygiene law , the amount of thirty-five dollars per month.
(ii) A person who neither receives nor is eligible to receive federal supplemental security income payments and/or additional state payments is entitled to a personal needs allowance as follows:
(A) for the personal expenses of a resident of a residential health care facility, as defined by section twenty-eight hundred one of the public health law , the amount of fifty dollars per month;
(B) for the personal expenses of a resident of an intermediate care facility operated or licensed by the office of mental retardation and developmental disabilities or a patient of a hospital operated by the office of mental health, as defined by subdivision ten of section 1.03 of the mental hygiene law , the amount of thirty-five dollars per month.
(iii) Notwithstanding the provisions of clauses (i) and (ii) of this subparagraph, the personal needs allowance for a person who is a veteran having neither a spouse nor a child, or a surviving spouse of a veteran having no child, who receives a reduced pension from the federal veterans administration, and who is a resident of a nursing facility, as defined in section 1919 of the federal social security act, 9shall be equal to such reduced monthly pension but shall not exceed ninety dollars per month.

(11) subject to the availability of federal financial participation, any amount, including earnings thereon, in a qualified NY ABLE account as established pursuant to article eighty-four of the mental hygiene law, any contributions to such NY ABLE account, and any distribution for qualified disability expenses from such account; provided however, that such exemption shall be consistent with section 529A of the Internal Revenue Code of 1986 , as amended.
(b)(1) [Expired March 31, 1988, pursuant to L.1984, c. 904, § 18. See, also, par. (b) below.] 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. 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 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 XVIII of the federal social security act shall be required to apply for and fully utilize such benefits in accordance with this chapter.

(2)(a) Notwithstanding any inconsistent provision of this chapter or any other law to the contrary, upon the request of the social services district the commissioner shall, subject to the approval of the director of the budget and the procurement of the applicable federal waiver, authorize demonstration projects in up to five social services districts, or portions thereof, for

the purpose of testing the feasibility of utilizing a special medical assistance income eligibility standard for certain persons in general hospitals on alternate care status who have been determined medically eligible for care in the community, in order to ease the financial burden of the legally responsible relatives. For any person sixty-five years of age or older residing in such social services districts, who is in a general hospital on alternate care status awaiting placement in a nursing home or intermediate care facility, as to whom it has been determined by the social services district that such person can be sustained in the community with in-home services at a cost not exceeding seventy-five percent of the average cost of care in a nursing home or intermediate care facility, and who meets such other criteria as the commissioner may establish, the social services district may, where it is beneficial to the applicant and legally responsible relatives, make a separate eligibility determination for such person, by adding the income of such person and support considered available from the legally responsible relative determined in accordance with regulations of the department, and comparing this sum to the medical assistance income exemption level for a household of one.

(b) In addition to the authorization provided for in clause (a), the commissioner shall, upon request of a social services district, authorize one social services district, or a portion thereof, to use the special medical assistance income eligibility standard established in clause (a) for persons: who are sixty-five years of age or older in general hospitals or in the community and who are medically eligible for placement in a nursing home or intermediate care facility; and who it has been determined by the social services district can be sustained in the community with in-home services at a cost not to exceed the average cost of care in a nursing home or intermediate care facility.

(c) No provision of this subparagraph shall be construed so as to deny any benefit to a person otherwise eligible for medical assistance in accordance with this chapter.

(d) Resource eligibility shall be established in accordance with the requirements of paragraph (a) of this subdivision.

(e) This subparagraph shall be effective if, and as long as, federal financial participation is available.

(b)(1) [See, also, par. (b) above.] 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 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 XVIII of the federal social security act [FN10]shall be required to apply for and fully utilize such benefits in accordance with this chapter.

(2) In evaluating the income and resources available to an applicant for or recipient of medical assistance, for purposes of determining eligibility for and the amount of such assistance, the department must consider assets held in or paid from trusts created by such applicant or recipient, as determined pursuant to the regulations of the department, in accordance with the provisions of this subparagraph.

(i) In the case of a revocable trust created by an applicant or recipient, as determined pursuant to regulations of the department: the trust corpus must be considered to be an available resource; payments made from the trust to or for the benefit of such applicant or recipient must be considered to be available income; and any other payments from the trust must be considered to be assets disposed of by such applicant or recipient for purposes of paragraph (d) of subdivision five of this section.

(ii) In the case of an irrevocable trust created by an applicant or recipient, as determined pursuant to regulations of the department: any portion of the trust corpus, and of the income generated by the trust corpus, from which no payment can under any circumstances be made to such applicant or recipient must be considered, as of the date of establishment of the trust, or, if later, the date on which payment to the applicant or recipient is foreclosed, to be assets disposed of by such applicant or recipient for purposes of paragraph (d) of subdivision five of this section; any portion of the trust corpus, and of the income generated by the trust corpus, from which payment could be made to or for the benefit of such applicant or recipient must be considered to be an available resource; payments made from the trust to or for the benefit of such applicant or recipient must be considered to be available income; and any other payments from the trust must be considered to be assets disposed of by such applicant or recipient for purposes of paragraph (d) of subdivision five of this section.

(iii) Notwithstanding the provisions of clauses (i) and (ii) of this subparagraph, in the case of an applicant or recipient who is disabled, as such term is defined in section 1614(a)(3) of the federal social security act, 9the department must not consider as available income or resources the corpus or income of the following trusts which comply with the provisions of the regulations authorized by clause (iv) of this subparagraph: (A) a trust containing the assets of such a disabled individual which was established for the benefit of the disabled individual while such individual was under sixty-five years of age by a parent, grandparent, legal guardian, or court of competent jurisdiction, if upon the death of such individual the state will receive all amounts remaining in the trust up to the total value of all medical assistance paid on behalf of such individual; (B) and a trust containing the assets of such a disabled individual established and managed by a non-profit association which maintains separate accounts for the benefit of disabled individuals, but, for purposes of investment and management of trust funds, pools the accounts, provided that accounts in the trust fund are established solely for the benefit of individuals who are disabled as such term is defined in section 1614(a)(3) of the federal social

security act by such disabled individual, a parent, grandparent, legal guardian, or court of competent jurisdiction, and to the extent that amounts remaining in the individual's account are not retained by the trust upon the death of the individual, the state will receive all such remaining amounts up to the total value of all medical assistance paid on behalf of such individual. Notwithstanding any law to the contrary, a not-for-profit corporation may, in furtherance of and as an adjunct to its corporate purposes, act as trustee of a trust for persons with disabilities established pursuant to this subclause, provided that a trust company, as defined in subdivision seven of section one hundred-c of the banking law , acts as co-trustee.

(iv) The department shall promulgate such regulations as may be necessary to carry out the provisions of this subparagraph. Such regulations shall include provisions for: assuring the fulfillment of fiduciary obligations of the trustee with respect to the remainder interest of the department or state; monitoring pooled trusts; applying this subdivision to legal instruments and other devices similar to trusts, in accordance with applicable federal rules and regulations; and establishing procedures under which the application of this subdivision will be waived with respect to an applicant or recipient who demonstrates that such application would work an undue hardship on him or her, in accordance with standards specified by the secretary of the federal department of health and human services. Such regulations may require: notification of the department of the creation or funding of such a trust for the benefit of an applicant for or recipient of medical assistance; notification of the department of the death of a beneficiary of such a trust who is a current or former recipient of medical assistance; in the case of a trust, the corpus of which exceeds one hundred thousand dollars, notification of the department of transactions tending to substantially deplete the trust corpus; notification of the department of any transactions involving transfers from the trust corpus for less than fair market value; the bonding of the trustee when the assets of such a trust equal or exceed one million dollars, unless a court of competent jurisdiction waives such requirement; and the bonding of the trustee when the assets of such a trust are less than one million dollars, upon order of a court of competent jurisdiction. The department, together with the department of financial services, shall promulgate regulations governing the establishment, management and monitoring of trusts established pursuant to subclause (B) of clause (iii) of this subparagraph in which a not-for-profit corporation and a trust company serve as co-trustees.

(v) Notwithstanding any acts, omissions or failures to act of a trustee of a trust which the department or a local social services official has determined complies with the provisions of clause (iii) and the regulations authorized by clause (iv) of this subparagraph, the department must not consider the corpus or income of any such trust as available income or resources of the applicant or recipient who is disabled, as such term is defined in section 1614(a)(3) of the federal social security act. The department's remedy for redress of any acts, omissions or failures to act by such a trustee which acts, omissions or failures are considered by the department to be inconsistent with the terms of the trust, contrary to applicable laws and regulations of the department, or contrary to the fiduciary obligations of the trustee shall be the commencement of an action or proceeding under subdivision one of section sixty-three of the executive law to safeguard or enforce the state's remainder interest in the trust, or such other action or proceeding as may be lawful and appropriate as to assure compliance by the trustee or to safeguard and enforce the state's remainder interest in the trust.

(3)(a) Social services officials shall authorize medical assistance for persons who would be eligible for such assistance except that their incomes exceed the applicable medical assistance income eligibility standard, which is determined according to paragraph (a) of subdivision two of this section, to become eligible for medical assistance by paying to their social services districts the amount by which their incomes exceed such income eligibility levels.

(b) Social services districts shall safeguard, by deposit in special accounts, any amounts paid to them by such recipients of medical assistance benefits. The amount of any medical assistance payments made to providers of medical assistance on behalf of such recipients, shall be charged against the amount in recipients' accounts. Districts shall, in accordance with their approved plans, periodically refund the amounts, if any, by which the amounts in recipients' accounts exceed the amounts of any medical assistance payments made on their behalf. Districts shall report to the department amounts in recipients' accounts that are equal to the amount of medical assistance payments made on recipients' behalf.

(c) Eligibility under this subparagraph shall be authorized only in accordance with plans submitted by social services districts and approved by the commissioner. Plans must be submitted by social services districts to the commissioner no later than February first, nineteen hundred ninety-six. The commissioner shall only approve plans that include a detailed description of how the district will administer the program, enroll recipients, safeguard monies in recipients' accounts, reconcile payments made to providers of medical assistance services with account balances and refund the amounts by which recipients' account funds exceed the amounts paid to providers on their behalf.

(d) By January first, nineteen hundred ninety-five, the department shall submit to the governor and the legislature a report evaluating the demonstration programs effect on enrollees' access to medical assistance care and services and any other subjects the commissioner deems relevant.

(e) Notwithstanding any other provision of law, administrative expenditures incurred by local social services districts in relation to this section shall be reimbursable as provided in subdivision one of section three hundred sixty-eight-a of this article.
(f) to (h) Repealed.

3. (a) Medical assistance shall be furnished to applicants in cases where, although such applicant has a responsible relative with sufficient income and resources to provide medical assistance as determined by the regulations of the department, the income and resources of the responsible relative are not available to such applicant because of the absence of such relative or the refusal or failure of such relative to provide the necessary care and assistance. In such cases, however, the furnishing of such assistance shall create an implied contract with such relative, and the cost thereof may be recovered from such relative in accordance with title six of article three and other applicable provisions of law.

(b)(i) When a legally responsible relative agrees or is ordered by a court or administrative tribunal of competent jurisdiction to provide health insurance or other medical care coverage for his or her dependents or other persons, and such dependents or other persons are applicants for, recipients of or otherwise entitled to receive medical assistance pursuant to this

title, the department and social services officials shall be subrogated to any rights that the responsible relative may have to obtain reimbursement from a third party for the costs of medical care for such dependents or persons.

(ii) Upon receipt of an application, or upon a determination of eligibility, for assistance pursuant to this title, the department and social services officials shall be deemed to have furnished assistance to any such dependent or person entitled to receive medical assistance pursuant to this title and shall be subrogated to any rights such person may have to third party reimbursement as provided in paragraph (b) of subdivision two of section three hundred sixty-seven-a of this title.

(iii) For purposes of determining whether a person is legally responsible for a person receiving assistance under this title, the following shall be dispositive: a copy of a support order issued pursuant to section four hundred sixteen or five hundred forty-five of the family court act or section two hundred thirty-six or two hundred forty of the domestic relations law ; an order described in paragraph (h) of subdivision four of this section; an order of a court or administrative tribunal of competent jurisdiction pursuant to the provisions of this subdivision; or any other order of a court or administrative tribunal of competent jurisdiction subject to the provisions of this subdivision. If a notice of subrogation as described in paragraph (b) of subdivision two of section three hundred sixty-seven-a of this title is accompanied by dispositive documentation that a person is legally responsible for a person receiving assistance under this title, any third party liable for reimbursement for the costs of medical care shall accord the department or any social services official the rights of and benefits available to the responsible relative that pertain to the provision of medical care to any persons entitled to medical assistance pursuant to this title for whom the relative is legally responsible.

(c) The provisions of this subdivision shall not be construed to diminish the authority of a social services official to bring a proceeding pursuant to the provisions of this chapter or other provisions of law (1) to compel any responsible relative to contribute to the support of any person receiving or liable to become in need of medical assistance, or (2) to recover from a recipient or a responsible relative the cost of medical assistance not correctly paid.

4. Special eligibility provisions.

(a) Transitional medical assistance.

(1) Notwithstanding any other provision of law, each family which was eligible for medical assistance pursuant to subparagraph four of paragraph (b) of subdivision one of this section in at least one of the six months immediately preceding the month in which such family became ineligible for such assistance because of income from the employment of the caretaker relative shall, while such family includes a dependent child, remain eligible for medical assistance for twelve calendar months immediately following the month in which such family would otherwise be determined to be ineligible for medical assistance pursuant to the provisions of this title and the regulations of the department governing income and resource limitations relating to eligibility determinations for families described in subparagraph four of paragraph (b) of subdivision one of this section.

(2)(i) Upon giving notice of termination of medical assistance provided pursuant to subparagraph four of paragraph (b) of subdivision one of this section, the department shall

notify each such family of its rights to extended benefits under subparagraph one of this paragraph and describe the conditions under which such extension may be terminated.

(ii) The department shall promulgate regulations implementing the requirements of this subparagraph and subparagraph one of this paragraph relating to the conditions under which extended coverage hereunder may be terminated, the scope of coverage, and the conditions under which coverage may be extended pending a redetermination of eligibility. Such regulations shall, at a minimum, provide for: termination of such coverage at the close of the first month in which the family ceases to include a dependent child; notice of termination prior to the effective date of any terminations; coverage under employee health plans and health maintenance organizations; and disqualification of persons for extended coverage benefits under this paragraph for fraud.

(3) Notwithstanding any inconsistent provision of law, each family which was eligible for medical assistance pursuant to subparagraph four of paragraph (b) of subdivision one of this section in at least three of the six months immediately preceding the month in which such family became ineligible for such assistance as a result, wholly or partly, of the collection or increased collection of spousal support pursuant to part D of title IV of the federal social security act, [FN11] shall, for purposes of medical assistance eligibility, be considered to be eligible for medical assistance pursuant to subparagraph four of paragraph (b) of subdivision one of this section for an additional four calendar months beginning with the month ineligibility for such assistance begins.

(b) Pregnant women and children.

(1) A pregnant woman eligible for medical assistance under subparagraph two or four of paragraph (b) of subdivision one of this section on any day of her pregnancy will continue to be eligible for such care and services through the end of the month in which the sixtieth day following the end of the pregnancy occurs, without regard to any change in the income of the family that includes the pregnant woman, even if such change otherwise would have rendered her ineligible for medical assistance.

(2) A child born to a woman eligible for and receiving medical assistance on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance on the date of such birth and to remain eligible for such assistance for a period of one year, so long as the child is a member of the woman's household and the woman remains eligible for such assistance or would remain eligible for such assistance if she were pregnant.

(3) A child under the age of nineteen who is determined eligible for medical assistance under the provisions of this section, shall, consistent with applicable federal requirements, remain eligible for such assistance until the earlier of:

(i) the last day of the month which is twelve months following the determination or redetermination of eligibility for such assistance; or

(ii) the last day of the month in which the child reaches the age of nineteen.

(4) An infant eligible under subparagraph two or four of paragraph (b) of subdivision one of this section who is receiving medically necessary in-patient services for which medical assistance is provided on the date the child attains one year of age, and who, but for attaining

such age, would remain eligible for medical assistance under such subparagraph, shall continue to remain eligible until the end of the stay for which in-patient services are being furnished.

(5) A child eligible under subparagraph three of paragraph (b) of subdivision one of this section who is receiving medically necessary in-patient services for which medical assistance is provided on the date the child attains nineteen years of age, and who, but for attaining such age, would remain eligible for medical assistance under this paragraph, shall continue to remain eligible until the end of the stay for which in-patient services are being furnished.

(6) A woman who was pregnant while in receipt of medical assistance who subsequently loses her eligibility for medical assistance shall have her eligibility for medical assistance continued for a period of twenty-four months from the end of the month in which the sixtieth day following the end of her pregnancy occurs, but only for Federal Title X services which are eligible for reimbursement by the federal government at a rate of ninety percent; provided, however, that such ninety percent limitation shall not apply to those services identified by the commissioner as services, including treatment for sexually transmitted diseases, generally performed as part of or as a follow-up to a service eligible for such ninety percent reimbursement; and provided further, however, that nothing in this paragraph shall be deemed to affect payment for such Title X services if federal financial participation is not available for such care, services and supplies.

(c) Continuous coverage for adults. Notwithstanding any other provision of law, a person whose eligibility for medical assistance is based on the modified adjusted gross income of the person or the person's household, and who loses eligibility for such assistance for a reason other than citizenship status, lack of state residence, or failure to provide a valid social security number, before the end of a twelve month period beginning on the effective date of the person's initial eligibility for such assistance, or before the end of a twelve month period beginning on the date of any subsequent determination of eligibility based on modified adjusted gross income, shall have his or her eligibility for such assistance continued until the end of such twelve month period, provided that federal financial participation in the costs of such assistance is available.

(d) Breast and cervical cancer treatment.

(1) Persons who are not eligible for medical assistance under the terms of section 1902(a)(10)(A)(i) of the federal social security act [FN12] are eligible for medical assistance coverage during the treatment of breast or cervical cancer, subject to the provisions of this paragraph.
(2)(i) Medical assistance is available under this paragraph to persons who are under sixty-five years of age, have been screened for breast and/or cervical cancer under the Centers for Disease Control and Prevention breast and cervical cancer early detection program and need treatment for breast or cervical cancer, and are not otherwise covered under creditable coverage as defined in the federal public health service act; [FN13] provided however that medical assistance shall be furnished pursuant to this clause only to the extent permitted under federal law, if, for so long as, and to the extent that federal financial participation is available therefor.
(ii) Medical assistance is available under this paragraph to persons who meet the requirements of clause (i) of this subparagraph but for their age and/or gender, who have been

screened for breast and/or cervical cancer under the program described in title one-A of article twenty-four of the public health law and need treatment for breast or cervical cancer, and are not otherwise covered under creditable coverage as defined in the federal public health service act; [FN13] provided however that medical assistance shall be furnished pursuant to this clause only if and for so long as the provisions of clause (i) of this subparagraph are in effect.
(3) Medical assistance provided to a person under this paragraph shall be limited to the period in which such person requires treatment for breast or cervical cancer.

(4)(i) The commissioner of health shall promulgate such regulations as may be necessary to carry out the provisions of this paragraph. Such regulations shall include, but not be limited to: eligibility requirements; a description of the medical services which are covered; and a process for providing presumptive eligibility when a qualified entity, as defined by the commissioner, determines on the basis of preliminary information that a person meets the requirements for eligibility under this paragraph.

(ii) For purposes of determining eligibility for medical assistance under this paragraph, resources available to such individual shall not be considered nor required to be applied toward the payment or part payment of the cost of medical care, services and supplies available under this paragraph.

(iii) An individual shall be eligible for presumptive eligibility for medical assistance under this paragraph in accordance with subdivision five of section three hundred sixty-four-i of this title.
(5) The commissioner of health shall, consistent with this title, make any necessary amendments to the state plan for medical assistance submitted pursuant to section three hundred sixty-three-a of this title, in order to ensure federal financial participation in expenditures under this paragraph. Notwithstanding any provision of law to the contrary, the provisions of clause (i) of subparagraph two of this paragraph shall be effective only if and for so long as federal financial participation is available in the costs of medical assistance furnished thereunder.
(e) Colon and prostate cancer treatment.

(1) Notwithstanding any other provision of law to the contrary, a person who has been screened or referred for screening for colon or prostate cancer by the cancer services screening program, as administered by the department of health, and has been diagnosed with colon or prostate cancer is eligible for medical assistance for the duration of his or her treatment for such cancer.

(2) Persons eligible for medical assistance under this paragraph shall have an income of two hundred fifty percent or less of the comparable federal income official poverty line as defined and annually revised by the federal office of management and budget.

(3) An individual shall be eligible for presumptive eligibility for medical assistance under this paragraph in accordance with subdivision five of section three hundred sixty-four-i of this title.
(4) Medical assistance is available under this paragraph to persons who are under sixty-five years of age, and are not otherwise covered under creditable coverage as defined in the federal Public Health Service Act. [FN13]

SOS § 367-a. Payments; insurance

1. (a) Any inconsistent provision of this chapter or other law notwithstanding, no assignment of the claim of any supplier of medical assistance shall be valid and enforceable as against any social services district or the department, and any payment with respect to any medical assistance shall be made to the person, institution, state department or agency or municipality supplying such medical assistance at rates established by the appropriate social services district and contained in its approved local medical plan, except as otherwise permitted or required by applicable federal and state provisions, including the regulations of the department; provided, however, that for those districts for whom the department has assumed payment responsibilities pursuant to section three hundred sixty-seven-b of this chapter, rates shall be established by the department, except as otherwise required by applicable provisions of federal or state law. A social services official may apply to the department for local variations in rates to be applicable, upon approval by the department, to recipients for whom such district is responsible. Claims for payment shall be made in such form and manner as the department shall determine.
(b) Where an applicant for or recipient of public assistance or medical assistance has health insurance in force, is enrolled in a group health insurance plan or group health plan covering care and other medical benefits provided under this title, payment or part-payment of the premium, co-insurance, any deductible amounts and other cost-sharing obligations for such insurance may also be made when deemed cost-effective pursuant to the regulations of the department.

(c) Any inconsistent provisions of this title or other law notwithstanding and to the extent that federal financial participation is available therefor and in accordance with the regulations of the commissioner, payment of the premium for coverage under a group health insurance plan or group health plan may be made under the medical assistance program on behalf of a person not otherwise entitled to public assistance or medical assistance if the social services official determines that the savings in expenditures to the program as a result of such coverage are likely to exceed the amount of the premiums paid and such person has:
(i) income (as determined in accordance with the methodology used to determine eligibility for benefits under the federal supplemental security income program) in an amount less than or equal to one hundred per cent of the federal income official poverty line (as defined and annually revised by the federal office of management and budget) applicable to the person's family size;
(ii) resources (as determined in accordance with the methodology used to determine eligibility for benefits under the federal supplemental security income program) less than or equal to twice the maximum amount an individual is permitted to have to obtain benefits under the federal supplemental security income program; and
(iii) coverage available under a group health insurance plan or an employer-based group health plan provided pursuant to title XXII of the federal public health services act, 1 section 4980B of the federal internal revenue code of 1986 , 2 or title VI of the employee retirement income security act of 1974. 3

(d) (i) Amounts payable under this title for medical assistance for items and services provided to eligible persons who are also beneficiaries under part A of title XVIII of the federal social

security act 4 and items and services provided to qualified medicare beneficiaries under part A of title XVIII of the federal social security act shall not be less than the amount of any deductible and co-insurance liability of such eligible persons or for which such eligible persons or such qualified medicare beneficiaries would be liable under federal law were they not eligible for medical assistance or were they not qualified medicare beneficiaries with respect to such benefits under such part A.

(ii) Amounts payable under this title for medical assistance for items and services provided to eligible persons who are also beneficiaries under part B of title XVIII of the federal social security act and items and services provided to qualified medicare beneficiaries under part B of title XVIII of the federal social security act shall not be less than the amount of any deductible liability of such eligible persons or for which such eligible persons or such qualified medicare beneficiaries would be liable under federal law were they not eligible for medical assistance or were they not qualified medicare beneficiaries with respect to such benefits under such part B.

(iii) With respect to items and services provided to eligible persons who are also beneficiaries under part B of title XVIII of the federal social security act and items and services provided to qualified medicare beneficiaries under part B of title XVIII of the federal social security act, the amount payable for services covered under this title shall be the amount of any co-insurance liability of such eligible persons pursuant to federal law were they not eligible for medical assistance or were they not qualified medicare beneficiaries with respect to such benefits under such part B, but shall not exceed the amount that otherwise would be made under this title if provided to an eligible person other than a person who is also a beneficiary under part B or is a qualified medicare beneficiary minus the amount payable under part B; provided, however, amounts payable under this title for items and services provided to eligible persons who are also beneficiaries under part B or to qualified medicare beneficiaries by an ambulance service under the authority of an operating certificate issued pursuant to article thirty of the public health law, a psychologist licensed under article one hundred fifty-three of the education law, or a facility under the authority of an operating certificate issued pursuant to article sixteen, thirty-one or thirty-two of the mental hygiene law and with respect to outpatient hospital and clinic items and services provided by a facility under the authority of an operating certificate issued pursuant to article twenty-eight of the public health law, shall not be less than the amount of any co-insurance liability of such eligible persons or such qualified medicare beneficiaries, or for which such eligible persons or such qualified medicare beneficiaries would be liable under federal law were they not eligible for medical assistance or were they not qualified medicare beneficiaries with respect to such benefits under part B.

(iv) If a health plan participating in part C of title XVIII of the federal social security act pays for items and services provided to eligible persons who are also beneficiaries under part B of title XVIII of the federal social security act or to qualified medicare beneficiaries, the amount payable for services under this title shall be eighty-five percent of the amount of any co-insurance liability of such eligible persons pursuant to federal law if they were not eligible for medical assistance or were not qualified medicare beneficiaries with respect to such benefits under such part B; provided, however, amounts payable under this title for items and services provided to eligible persons who are also beneficiaries under part B or to qualified medicare beneficiaries by an ambulance service under the authority of an operating certificate issued pursuant to article thirty of the public health law, or a psychologist licensed under article one hundred fifty-three of the education law, shall not be less than the amount of any co-insurance liability of such eligible persons or such qualified medicare beneficiaries, or for which such

eligible persons or such qualified medicare beneficiaries would be liable under federal law were they not eligible for medical assistance or were they not qualified medicare beneficiaries with respect to such benefits under part B.

(e) Amounts payable under this title for medical assistance in the form of clinic services pursuant to article twenty-eight of the public health law and article sixteen of the mental hygiene law provided to eligible persons diagnosed with a developmental disability who are also beneficiaries under part B of title XVIII of the federal social security act, or provided to persons diagnosed with a developmental disability who are qualified medicare beneficiaries under part B of title XVIII of such act shall not be less than the approved medical assistance payment level less the amount payable under part B.

(f) Amounts payable under this title for medical assistance in the form of outpatient mental health services under article thirty-one or outpatient chemical dependence services including opioid treatment services under article thirty-two of the mental hygiene law provided to eligible persons who are also beneficiaries under part B of title XVIII of the federal social security act or provided to qualified medicare beneficiaries under part B of title XVIII of such act shall not be less than the approved medical assistance payment level less the amount payable under part B.

(g) Notwithstanding any provision of this section to the contrary, amounts payable under this title for medical assistance in the form of hospital outpatient services or diagnostic and treatment center services pursuant to article twenty-eight of the public health law provided to eligible persons who are also beneficiaries under part B of title XVIII of the federal social security act or provided to qualified medicare beneficiaries under part B of title XVIII of such act shall not exceed the approved medical assistance payment level less the amount payable under part B.

2. (a) Any inconsistent provision of this chapter notwithstanding, provision for medical care and other medical benefits available under this title may be made, in whole or in part, either under this title or other appropriate provisions of this chapter, through insurance or other prepaid plans, in accordance with the regulations of the department.

(b) Any inconsistent provision of this chapter or other law notwithstanding, upon furnishing assistance under this title to any applicant or recipient of medical assistance, the local social services district or the department shall be subrogated, to the extent of the expenditures by such district or department for medical care furnished, to any rights such person may have to medical support or reimbursement from liable third parties, including but not limited to health insurers, self-insured plans, group health plans, service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service. For purposes of this section, the term medical support shall mean the right to support specified as support for the purpose of medical care by a court or administrative order. The right of subrogation does not attach to insurance benefits paid or provided under any health insurance policy prior to the receipt of written notice of the exercise of subrogation rights by the carrier issuing such insurance, nor shall such right of subrogation attach to any benefits which may be claimed by a social services official or the department, by agreement or other established procedure, directly from an insurance carrier. No right of subrogation to insurance benefits available under any health insurance policy shall be enforceable unless written notice of the

exercise of such subrogation right is received by the carrier within three years from the date services for which benefits are provided under the policy or contract are rendered. Liable third parties shall not deny a claim made by a social services official or the department in conformance with this paragraph solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim. The local social services district or the department shall also notify the carrier when the exercise of subrogation rights has terminated because a person is no longer receiving assistance under this title. Such carrier shall establish mechanisms to maintain the confidentiality of all individually identifiable information or records. Such carrier shall limit the use of such information or record to the specific purpose for which such disclosure is made, and shall not further disclose such information or records.

(c) In accordance with regulations of the department and to the extent authorized by federal law and regulation, the social services district is authorized to retain, in addition to amounts retained as repayment for its share of the costs of medical assistance provided, a portion of the federal share of the amount collected as medical support or third party benefits assigned under paragraph (f) of subdivision four of section three hundred sixty-six of this article, when such district, or other governmental agency pursuant to an agreement with such district, has collected such medical support or third party benefits on behalf of a person receiving medical assistance whose rights to medical support or third party benefits have been assigned to the state or to the appropriate social services official. Where more than one district has been involved in enforcing or collecting such amounts, the federal incentive shall be apportioned among each such district in accordance with the regulations of the department.

3. (a) Payment of premiums for enrolling qualified disabled and working individuals and qualified medicare beneficiaries under Part A of title XVIII of the federal social security act 5 and for enrolling such beneficiaries and eligible recipients of public assistance under part B of title XVIII of the federal social security act, 6 together with the costs of the applicable co-insurance and deductible amounts on behalf of such beneficiaries, and recipients, and premiums under section 1839 of the federal social security act 7 for persons who would be qualified medicare beneficiaries except that their incomes exceed one hundred percent of the federal income poverty line applicable to the person's family size but, in calendar years nineteen hundred ninety-three and nineteen hundred ninety-four, is less than one hundred ten percent of such poverty line and, in calendar year beginning in nineteen hundred ninety-five, is less than one hundred twenty percent of such poverty line shall be made and the cost thereof borne by the state or by the state and social services districts, respectively, in accordance with the regulations of the department, provided, however, that the share of the cost to be borne by a social services district, if any, shall in no event exceed the proportionate share borne by such district with respect to other expenditures under this title. Moreover, if the director of the budget approves, payment of premiums for enrolling persons who have been determined to be eligible for medical assistance only may be made and the cost thereof borne or shared pursuant to this subdivision.

(b)(1) For purposes of this subdivision, “qualified medicare beneficiaries” are those persons who are entitled to hospital insurance benefits under part A of title XVIII of the federal social security act, whose income does not exceed one hundred percent of the official federal poverty line applicable to the person's family size and whose resources do not exceed twice the

maximum amount of resources a person may have in order to qualify for benefits under the federal supplemental security income program of title XVI of the federal social security act 8, as determined for purposes of such program.
(2) Notwithstanding any provision of subparagraph one of this paragraph to the contrary, to the extent that federal financial participation is available, a person whose resources are in excess of the amount specified but otherwise meets the requirements of subparagraph one of this paragraph shall be considered a “qualified medicare beneficiary” for the purposes of this subdivision. The commissioner is authorized to submit amendments to the state plan for medical assistance and/or submit one or more applications for waivers of the federal social security act, to obtain the federal approvals necessary to implement this subparagraph.

(c)(1) For purposes of this subdivision, “qualified disabled and working individuals” are individuals who are not otherwise eligible for medical assistance and:
(i) who are entitled to enroll for hospital insurance benefits under section 1818A of part A of title XVIII of the federal social security act 9;
(ii) whose income does not exceed two hundred percent of the official federal poverty line applicable to the person's family size; and
(iii) whose resources do not exceed twice the maximum amount of resources that an individual or a couple, in the case of a married individual, may have and obtain federal supplemental security income benefits under title XVI of the federal social security act, as determined for purposes of that program.
(2) For purposes of this paragraph, income and resources are determined by the same methodology as is used for determining eligibility under the federal supplemental security income benefits under title XVI of the federal social security act.

(d)(1) Beginning April first, two thousand two and to the extent that federal financial participation is available at a one hundred percent federal Medical assistance percentage and subject to sections 1933 and 1902(a)(10)(E)(iv) of the federal social security act [FN10], medical assistance shall be available for full payment of medicare part B premiums for individuals (referred to as qualified individuals 1) who are entitled to hospital insurance benefits under part A of title XVIII of the federal social security act and whose income exceeds the income level established by the state and is at least one hundred twenty percent, but less than one hundred thirty-five percent, of the federal poverty level, for a family of the size involved and who are not otherwise eligible for medical assistance under the state plan;
(2) Premium payments for the individuals described in subparagraph one of this paragraph will be one hundred percent federally funded up to the amount of the federal allotment. The department shall discontinue enrollment into the program when the part B premium payments made pursuant to subparagraph one of this paragraph meet the yearly federal allotment.
(3) The commissioner of health shall develop a simplified application form, consistent with federal law, for payments pursuant to this section. The commissioner of health, in cooperation with the office for the aging, shall publicize the availability of such payments to medicare beneficiaries.

(e)(1) Payment of premiums for enrolling individuals in qualified health plans offered through a health insurance exchange established pursuant to the federal Patient Protection and

Affordable Care Act (P.L. 111-148) [FN11], as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), shall be available to individuals who:
(i) immediately prior to being enrolled in the qualified health plan, were or would have been eligible under the family health plus program as a parent or stepparent of a child under the age of twenty-one, and whose MAGI household income, as defined in subparagraph eight of paragraph (a) of subdivision one of section three hundred sixty-six of this title, exceeds one hundred thirty-three percent of the federal poverty line for the applicable family size;
(ii) are not otherwise eligible for medical assistance under this title; and
(iii) are enrolled in a standard health plan in the silver level, as defined in 42 U.S.C. 18022 .
(2) Payment pursuant to this paragraph shall be for premium obligations of the individual under the qualified health plan and shall continue only if and for so long as the individual's MAGI household income exceeds one hundred thirty-three percent, but does not exceed one hundred fifty percent, of the federal poverty line for the applicable family size, or, if earlier, until the individual is eligible for enrollment in a standard health plan pursuant to section three hundred sixty-nine-gg of this article.
(3) The commissioner of health shall submit amendments to the state plan for medical assistance and/or submit one or more applications for waivers of the federal social security act as may be necessary to receive federal financial participation in the costs of payments made pursuant to this paragraph; provided further, however, that nothing in this subparagraph shall be deemed to affect payments for premiums pursuant to this paragraph if federal financial participation in the costs of such payments is not available.

4. No social services district shall make final payments pursuant to title XIX of the federal social security act [FN12] for benefits available under title XVIII of such act [FN13] without documentation that title XVIII claims have been filed and denied.

5. (a) When medical care, services and supplies are furnished an eligible person on behalf of a social services district under this title, such social services district is authorized to utilize any appropriate organization as a fiscal intermediary to audit and make payment for such district's share of the cost of such care, services and supplies.
(b) To carry out the purposes of paragraph (a), the department, on behalf of itself and any of the social services districts, may enter into agreements with appropriate organizations to act as fiscal intermediaries.

6. (a) Notwithstanding any inconsistent provision of law, payment for claims for services as specified in paragraph (d) of this subdivision furnished to eligible persons under this title, subject to paragraph (b) of this subdivision shall be reduced in accordance with the provisions of paragraph (c) of this subdivision by an amount not to exceed the maximum amount authorized by federal law and regulations as a co-payment amount, which co-payment amount the provider of such services may charge the recipient, provided, however, no provider may deny such services to an individual eligible for services based on the individual's inability to pay the co-payment amount.
(b) [Eff. until Oct. 1, 2015, upon occurrence of contingency pursuant to L.2015, c. 57, pt. B, § 60 . See, also, par. (b) below.] Co-payments shall apply to all eligible persons for the services defined in paragraph (d) of this subdivision with the exception of:
(i) individuals under twenty-one years of age;

(ii) pregnant women;
(iii) individuals who are inpatients in a medical facility who have been required to spend all of their income for medical care, except their personal needs allowance or residents of community based residential facilities licensed by the office of mental health or the office of mental retardation and developmental disabilities who have been required to spend all of their income, except their personal needs allowance;
(iv) individuals enrolled in health maintenance organizations or other entities which provide comprehensive health services, or other managed care programs for services covered by such programs, except that such persons, other than persons otherwise exempted from co-payments pursuant to subparagraphs (i), (ii), (iii) and (v) of this paragraph, and other than those persons enrolled in a managed long term care program, shall be subject to co-payments as described in subparagraph (v) of paragraph (d) of this subdivision;
(v) individuals whose family income is less than one hundred percent of the federal poverty line, as defined in subparagraph four of paragraph (a) of subdivision one of section three hundred sixty-sixof this title, for a family of the same size; and
(vi) any other individuals required to be excluded by federal law or regulations.
(b) [Eff. Oct. 1, 2015, upon occurrence of contingency pursuant to L.2015, c. 57, pt. B, § 60 . See, also, par. (b) above.] Co-payments shall apply to all eligible persons for the services defined in paragraph (d) of this subdivision with the exception of:
(i) individuals under twenty-one years of age;
(ii) pregnant women;
(iii) individuals who are inpatients in a medical facility who have been required to spend all of their income for medical care, except their personal needs allowance or residents of community based residential facilities licensed by the office of mental health or the office of mental retardation and developmental disabilities who have been required to spend all of their income, except their personal needs allowance;
(iv) individuals whose family income is less than one hundred percent of the federal poverty line, as defined in subparagraph four of paragraph (a) of subdivision one of section three hundred sixty-sixof this title, for a family of the same size; and
(v) any other individuals required to be excluded by federal law or regulations.
(b-1) The commissioner is authorized to submit any request or application to the Centers for Medicare and Medicaid Services as may be necessary to be granted a waiver of the requirement for the department of health to calculate its Medicaid payments to managed care organizations to include cost sharing established under the state plan for medical assistance for enrollees who are not exempt from cost sharing. In the absence of such a waiver, the commissioner shall adjust Medicaid payments to managed care organizations beginning October first, two thousand fifteen or on the date the Centers for Medicare and Medicaid Services commences enforcement of such requirement, whichever is later.
(c) [Repealed March 31, 2019, pursuant to L.1991, c. 165, § 62, subd. (c).] (i) Co-payments charged pursuant to this subdivision for non-institutional services shall not exceed the following table, provided, however, that the department may establish standard co-payments for services based upon the average or typical payment for that service:

State's payment for the services	Maximum co-payment chargeable to recipient
$10 or less	$ .50
$10.01 to $25	$1.00
$25.01 to $50	$2.00
$50.01 or more	$3.00

(ii) co-payments charged pursuant to this subdivision for each discharge for inpatient care shall be twenty-five dollars.
(iii) Notwithstanding any other provision of this paragraph, co-payments charged for each generic prescription drug dispensed shall be one dollar and for each brand name prescription drug dispensed shall be three dollars; provided, however, that the co-payments charged for each brand name prescription drug on the preferred drug list established pursuant to section two hundred seventy-two of the public health law or, for managed care providers operating pursuant to section three hundred sixty-four-j of this title, for each brand name prescription drug on a managed care provider's formulary that such provider has designated as a preferred drug, and the co-payments charged for each brand name prescription drug reimbursed pursuant to subparagraph (ii) of paragraph (a-1) of subdivision four of section three hundred sixty-five-a of this title shall be one dollar.
(iv) When an individual is initially dispensed or prescribed a seven or fewer days supply of an opioid pursuant to paragraph (b) of subdivision five of section three thousand three hundred thirty-one of the public health law , and is subsequently dispensed or prescribed an additional supply of such opioid for the same underlying condition, the total co-payment that may be charged to such an individual for the initial prescription plus all subsequent prescriptions for the same underlying condition for up to a total of thirty-days supply of such opioid shall not exceed the amount set forth in subparagraph (iii) of this paragraph.
(d) Co-payments shall apply to the following services, subject to such exceptions for subcategories of these services as recognized by the commissioner in regulations, provided in accordance with section three hundred sixty-five-a of this article and the regulations of the department, to the extent permitted by title XIX of the federal social security act:
(i) in-patient care in a general hospital, as defined in subdivision ten of section twenty-eight hundred one of the public health law ;
(ii) out-patient hospital and clinic services except for mental health services, mental retardation and developmental disability services, alcohol and substance abuse services and methadone maintenance services;
(iii) [See Suspension of Effectiveness of Subd. 6, Par. (d), Cl. (iii), Pursuant to L.1992, c. 795 , note below.] home health services, including services provided under the long term home health care program, provided however, home health providers shall not require employees providing services in the home to collect the co-payment amount;
(iv) sickroom supplies;

(v) drugs, excepting psychotropic drugs and drugs with FDA approved indications for the treatment of tuberculosis as specified by the department and those drugs intended for use by residents of adult care facilities licensed by the department of health who have been required to spend all of their income, except their personal needs allowance;
(vi) clinical laboratory services;
(vii) x-rays;
(viii) emergency room services provided for non-urgent or non-emergency medical care, provided however, co-payments shall not be required for emergency services or family planning services and supplies;
(e) In the period from January first, nineteen hundred ninety-three to March thirty-first, nineteen hundred ninety-three no recipient shall be required to pay more than a total of fifty dollars in co-payments required by this subdivision for drugs, nor shall reductions in payments as a result of such co-payments exceed fifty dollars for any recipient.
(f) (i) In the year commencing April first, nineteen hundred ninety-three and for each year thereafter, and ending in the year concluding on March thirty-first, two thousand five, no recipient shall be required to pay more than a total of one hundred dollars in co-payments required by this subdivision, nor shall reductions in payments as a result of such co-payments exceed one hundred dollars for any recipient.
(ii) In the year commencing April first, two thousand five and for each year thereafter, no recipient shall be required to pay more than a total of two hundred dollars in co-payments required by this subdivision, nor shall reductions in payments as a result of such co-payments exceed two hundred dollars for any recipient.
(g) The commissioner shall promptly:
(i) promulgate a regulation making it an unacceptable practice under the medical assistance program for a provider to deny services to an individual eligible for services based on the individual's inability to pay the co-pay amount required by this subdivision;
(ii) establish and maintain a toll-free hotline which may be used to report a violation of the regulation promulgated pursuant to subparagraph (i) of this paragraph; and
(iii) provide notice to all recipients summarizing their rights and obligations under this subdivision.

7. (a) Every manufacturer or wholesaler of drugs, prescriptions or poisons registered under the provisions of section sixty-eight hundred eight of the education law , shall, upon request of the department for any information pertaining to wholesale prices charged to pharmacists for any drugs available under the medical assistance program, make the requested information available to the department on a monthly basis, or such other periodic basis as the department shall request.
(b) The department shall provide for financial arrangements with any manufacturer or wholesaler of drugs, prescriptions or poisons as may be necessary to reimburse such manufacturer or wholesaler for its actual and necessary costs included in furnishing the requested information.
(c) Any information obtained pursuant to the provisions of this subdivision shall not be made available for public inspection or copying under the provisions of article six of the public officers law. The department shall not disclose such information to any person, firm, department or agency, except any state agency or department as may be necessary for the administration of the medical assistance program under the provisions of this chapter or any other law.

(d) Notwithstanding any inconsistent provision of law, if a manufacturer (as defined under section 1927 of the federal social security act) has entered into a rebate agreement with the department or with the federal secretary of health and human services on behalf of the department under section 1927 of the federal social security act, [FN14] the department shall reimburse for covered outpatient drugs which are dispensed under the medical assistance program to all persons in receipt of medical assistance benefits as a result of their eligibility having been established under subparagraph one or nine of paragraph (a) of subdivision one of section three hundred sixty-six of this title, and which are dispensed to all persons eligible for health care services as a result of their eligibility having been established under subdivision two of section three hundred sixty-nine-ee of this article, only pursuant to the terms of the rebate agreement between the department and such manufacturer; provided, however, that any agreement between the department and a manufacturer entered into before August first, nineteen hundred ninety-one, shall be deemed to have been entered into on April first, nineteen hundred ninety-one; and provided further, that if a manufacturer has not entered into an agreement with the department before August first, nineteen hundred ninety-one, such agreement shall not be effective until April first, nineteen hundred ninety-two, unless such agreement provides that rebates will be retroactively calculated as if the agreement had been in effect on April first, nineteen hundred ninety-one. The rebate agreement between such manufacturer and the department shall utilize for single source drugs and innovator multiple source drugs the identical formula used to determine the basic rebate for federal financial participation single source drugs and innovator multiple source drugs, pursuant to paragraph one of subdivision (c) of section 1927 of the federal social security act, to determine the amount of the rebate pursuant to this paragraph. The rebate agreement between such manufacturer and the department shall utilize for non-innovator multiple source drugs the identical formula used to determine the basic rebate for federal financial participation non-innovator multiple source drugs, pursuant to paragraphs three and four of subdivision (c) of section 1927 of the federal social security act, to determine the amount of the rebate pursuant to this paragraph. The terms and conditions of such rebate agreement with respect to periodic payment of the rebate, provision of information by the department, audits, manufacturer provision of information verification of surveys, penalties, confidentiality of information, and length of the agreement shall apply to drugs of the manufacturer dispensed under the medical assistance program to all persons in receipt of medical assistance benefits as a result of their eligibility having been established under subparagraph one or nine of paragraph (a) of subdivision one of section three hundred sixty-six of this title, and which are dispensed to all persons eligible for health care services as a result of their eligibility having been established under subdivision two of section three hundred sixty-nine-ee of this article. The department in providing utilization data to a manufacturer (as provided for under section 1927.4(b)(1)(A) of the federal social security act) shall provide such data by zip code, if requested, for drugs covered under a rebate agreement.

(e) [Expires and deemed repealed March 31, 2020, pursuant to L.2015, c. 57, pt. B, § 60 .] During the period from April first, two thousand fifteen through March thirty-first, two thousand seventeen, the commissioner may, in lieu of a managed care provider, negotiate directly and enter into an agreement with a pharmaceutical manufacturer for the provision of supplemental rebates relating to pharmaceutical utilization by enrollees of managed care providers pursuant to section three hundred sixty-four-j of this title and may also negotiate directly and enter into such an agreement relating to pharmaceutical utilization by medical assistance recipients not

so enrolled. Such rebates shall be limited to drug utilization in the following classes: antiretrovirals approved by the FDA for the treatment of HIV/AIDS and hepatitis C agents for which the pharmaceutical manufacturer has in effect a rebate agreement with the federal secretary of health and human services pursuant to 42 U.S.C. § 1396r-8 , and for which the state has established standard clinical criteria. No agreement entered into pursuant to this paragraph shall have an initial term or be extended beyond March thirty-first, two thousand twenty.

(i) The manufacturer shall not pay supplemental rebates to a managed care provider, or any of a managed care provider's agents, including but not limited to any pharmacy benefit manager on the two classes of drugs subject to this paragraph when the state is collecting supplemental rebates and standard clinical criteria are imposed on the managed care provider.

(ii) The commissioner shall establish adequate rates of reimbursement which shall take into account both the impact of the commissioner negotiating such rebates and any limitations imposed on the managed care provider's ability to establish clinical criteria relating to the utilization of such drugs. In developing the managed care provider's reimbursement rate, the commissioner shall identify the amount of reimbursement for such drugs as a separate and distinct component from the reimbursement otherwise made for prescription drugs as prescribed by this section.

(iii) The commissioner shall submit a report to the temporary president of the senate and the speaker of the assembly annually by December thirty-first. The report shall analyze the adequacy of rates to managed care providers for drug expenditures related to the classes under this paragraph.

(iv) Nothing in this paragraph shall be construed to require a pharmaceutical manufacturer to enter into a supplemental rebate agreement with the commissioner relating to pharmaceutical utilization by enrollees of managed care providers pursuant to section three hundred sixty-four-j of this title or relating to pharmaceutical utilization by medical assistance recipients not so enrolled.

(v) All clinical criteria, including requirements for prior approval, and all utilization review determinations established by the state as described in this paragraph for either of the drug classes subject to this paragraph shall be developed using evidence-based and peer-reviewed clinical review criteria in accordance with article two-A of the public health law, as applicable.

(vi) All prior authorization and utilization review determinations related to the coverage of any drug subject to this paragraph shall be subject to article forty-nine of the public health law, section three hundred sixty-four-j of this title, and article forty-nine of the insurance law, as applicable. Nothing in this paragraph shall diminish any rights relating to access, prior authorization, or appeal relating to any drug class or drug afforded to a recipient under any other provision of law.

(f) [Expires and deemed repealed March 31, 2018, pursuant to L.2016, c. 59, pt. B, § 31 .] (1) The department may require manufacturers of drugs other than single source drugs and innovator multiple source drugs, as such terms are defined in 42 U.S.C. § 1396r-8(k) , to provide rebates to the department for any drug that has increased more than three hundred percent of its state maximum acquisition cost (SMAC), on or after April 1, 2016, in comparison to its SMAC at any time during the course of the preceding twelve months. The required rebate shall be limited to the amount by which the current SMAC for the drug exceeds three hundred percent of the SMAC for the same drug at any time during the course of the preceding twelve months. Such rebates shall be in addition to any rebates payable to the department

pursuant to any other provision of federal or state law. Nothing herein shall affect the department's obligation to reimburse for covered outpatient drugs pursuant to paragraph (d) of this subdivision.
(2) Except as provided in subparagraph three of this paragraph, the commissioner shall not determine any further rebates to be payable pursuant to this paragraph once the Centers for Medicare and Medicaid Services has adopted a final methodology for determining the amount of additional rebates under the federal generic drug price increase rebate program pursuant to 42 U.S.C. § 1396r-8 (c)(3) , as amended by section 602 of the Bipartisan Budget Act of 2015.
(3) During state fiscal year 2016-2017, if the Centers for Medicare and Medicaid Services has adopted a final methodology for determining the amount of additional rebates under the federal generic drug price increase rebate program pursuant to 42 U.S.C. § 1396r-8 (c)(3) , as amended by section 602 of the Bipartisan Budget Act of 2015, the department may collect for a given drug the portion of the rebate determined under this paragraph that is in excess of the rebate required by such federal rebate program.
(4) The additional rebates authorized pursuant to this paragraph shall apply to generic prescription drugs dispensed to enrollees of managed care providers pursuant to section three hundred sixty-four-j of this title and to generic prescription drugs dispensed to Medicaid recipients who are not enrollees of such providers.
(5) Beginning in two thousand seventeen, the department shall provide an annual report to the legislature no later than February first setting forth:
(i) The number of drugs that exceeded the ceiling price established in this paragraph during the preceding year in comparison to the number of drugs that experienced at least a three hundred percent price increase during two thousand fourteen and two thousand fifteen;
(ii) The average percent amount above the ceiling price of drugs that exceeded the ceiling price in the preceding year in comparison to the number of drugs that experienced a price increase more than three hundred percent during two thousand fourteen and two thousand fifteen;
(iii) The number of generic drugs available to enrollees in Medicaid fee for service or Medicaid managed care, by fiscal quarter, in the preceding year in comparison to the drugs available, by fiscal quarter, during two thousand fourteen and two thousand fifteen; and
(iv) The total drug spend on generic drugs for the preceding year in comparison to the total drug spend on generic drugs during two thousand fourteen and two thousand fifteen.

8. [Eff. until July 1, 2020, pursuant to L.1989, c. 723, § 21 . See, also, subd. 8 below.] No government agency shall purchase, pay for, or make reimbursement or grants-in-aid for any service in a residential treatment facility for children and youth or a comprehensive psychiatric emergency program unless at the time such service was provided, the residential treatment facility for children and youth or comprehensive psychiatric emergency program possessed a valid operating certificate authorizing such service. Notwithstanding any inconsistent provision of law, no government agency shall make payments pursuant to this title or title nineteen of the federal social security act to a residential treatment facility for children and youth for service to a person whose need for care and treatment in such a facility was not certified pursuant to section 9.51 of the mental hygiene law .

8. [Eff. July 1, 2020, pursuant to L.1989, c. 723, § 21 . See, also, subd. 8 above.] No government agency shall purchase, pay for, or make reimbursement or grants-in-aid for any service in a residential treatment facility for children and youth unless at the time such service was provided, the residential treatment facility for children and youth possessed a valid operating certificate authorizing such service. Notwithstanding any inconsistent provision of law, no government agency shall make payments pursuant to this title or title nineteen of the federal social security act to a residential treatment facility for children and youth for service to a person whose need for care and treatment in such a facility was not certified pursuant to section 9.51 of the mental hygiene law .

9. [Eff. March 31, 2017, pursuant to L.1998, c. 19, § 4 .] Notwithstanding any inconsistent provision of law or regulation to the contrary, for those drugs which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law and for which payment is authorized pursuant to paragraph (g) of subdivision two of section three hundred sixty-five-a of this title, payments under this title shall be made at the following amounts:
(a) for drugs provided by medical practitioners and claimed separately by the practitioners, the actual cost of the drugs to the practitioners; and
(b) for drugs dispensed by pharmacies:
(i) if the drug dispensed is a multiple source prescription drug for which an upper limit has been set by the federal health care financing administration, an amount equal to the specific upper limit set by such federal agency for the multiple source prescription drug, and
(ii) if the drug dispensed is a multiple source prescription drug or a brand-name prescription drug for which no specific upper limit has been set by such federal agency, the lower of the estimated acquisition cost of such drug to pharmacies, or the dispensing pharmacy's usual and customary price charged to the general public. Estimated acquisition cost means the average wholesale price of a prescription drug based upon the package size dispensed from, as reported by the prescription drug pricing service used by the department, less ten percent thereof, and updated monthly by the department.
(c) Notwithstanding subparagraph (i) of paragraph (b) of this subdivision, if a qualified prescriber certifies “brand medically necessary” or “brand necessary” in his or her own handwriting directly on the face of a prescription for a multiple source drug for which a specific upper limit of reimbursement has been established by the federal agency, in addition to writing “d a w” in the box provided for such purpose on the prescription form, payment under this title for such drug must be made under the provisions of subparagraph (ii) of such paragraph.
(d) In addition to the amounts paid pursuant to paragraph (b) of this subdivision to pharmacies for those drugs which may not be dispensed without a prescription, as required by section sixty-eight hundred ten of the education law and for which payment is authorized pursuant to paragraph (g) of subdivision two of section three hundred sixty-five-a of this title, the department shall pay a pharmacy dispensing fee for each such prescription drug dispensed, which dispensing fee shall not be less than the following amounts:
(i) for prescription drugs categorized as generic by the prescription drug pricing service used by the department, five dollars and fifty cents per prescription; and
(ii) for prescription drugs categorized as brand-name prescription drug by the prescription drug pricing service used by the department, four dollars and fifty cents per prescription.

10. Any provider except for those providers certified under article twenty-eight of the public health law, of ordered services or supplies under the medical assistance program may be required to provide financial security to assure that funds are available to repay any overpayments made to the provider under this title and to assure the financial security of the medical assistance program. For the purposes of this subdivision, “ordered services or supplies” shall mean those services or supplies described in paragraphs (g) , (i) and (j) of subdivision two of section three hundred sixty-five-a of this title.
(a) Any financial security required by this subdivision must meet the requirements of this paragraph. Financial security may be provided through a bond with a corporate surety, from a company authorized to do business in this state, or an irrevocable letter of credit or certificate of deposit from a New York state or federally chartered bank, trust company, savings bank or savings and loan association qualified to do business in New York state and insured by the federal deposit insurance corporation. [FN15]
(b) The bond, letter of credit or certificate of deposit shall be payable in favor of the people of the state of New York for the purpose of indemnifying the medical assistance program against any overpayments made to the provider.
(c) The bond, letter of credit or certificate of deposit filed and maintained pursuant to this section shall not be cancelled, revoked or terminated except after notice to, and with the consent of, the department at least forty-five days in advance of such cancellation, revocation or termination.
(d) The department may bring and maintain an action against the provider and the surety or bank, trust company, savings bank or savings and loan association for any claimed overpayments made to the provider.
(e) Financial security shall not be required for providers which do not submit claims for payment under the medical assistance program exceeding five hundred thousand dollars per annum or forty-two thousand dollars per month.
(f) Financial security shall be in an amount equal to the provider's estimated claims for payment for a one year period and may be adjusted bi-annually in accordance with the dollar amount of claims actually submitted. If the commissioner is satisfied from an investigation of the financial condition of a provider that the provider is solvent and possessed of sufficient assets to provide reasonable assurance of recovery of any overpayments, the commissioner may modify the amount of financial security to be provided by such provider.
(g) Financial security must be submitted by a provider upon initial application for enrollment as a provider of medical assistance and with each subsequent enrollment. A change in ownership of a provider shall not release, cancel or terminate liability under this section under any bond, letter of credit or certificate of deposit filed for a provider while such bond, letter of credit or certificate of deposit is in effect unless the transferee, purchaser, successor or assignee of such provider obtains a bond, letter of credit or certificate of deposit under this section for the benefit of such new owner. All providers enrolled in the medical assistance program on the effective date of this subdivision [FN16] will be required to submit financial security within ninety days of notice of such requirements by the department.
(h) The department may make the submission of the financial security required by this subdivision a condition of participation in the medical assistance program.

11. (a) Any inconsistent provisions of this title or other law notwithstanding, no health insurer, self-insured plan, managed care organization, pharmacy benefit manager, or other

party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, employer or organization who has a plan, including an employee retirement income security act or service benefit plan, providing care and other medical benefits for persons, whether by insurance or otherwise, shall exclude a person from eligibility, coverage or entitlement to medical benefits by reason of the eligibility of such person for medical assistance under this title, or by reason of the fact that such person would, except for such plan, be eligible for benefits under this title.

(b) Any inconsistent provisions of this title or other law notwithstanding, no insurer may impose requirements on the department or a social services district which has been assigned the rights of an individual who is eligible for medical assistance under this title and who is covered for health benefits from the insurer, that are different from requirements applicable to an agent or assignee of any other individual so covered.

(c) Any inconsistent provisions of this title or other law notwithstanding, the department may, to the extent necessary to reimburse the department and the social services districts for expenditures under this title, certify to the commissioner of taxation and finance pursuant to section one hundred seventy-one-f of the tax law amounts to be withheld from tax refunds otherwise due to any individual who is required by court order to provide medical support in the form of health insurance benefits for a child who is eligible for medical assistance under this title and who has received payment from a third-party for the cost of such services for such child but has not used such payments to reimburse either the other parent or guardian of such child or the provider of such services or the appropriate social services district; provided however, that any claims for current or past-due child support shall take priority over any such claims for the costs of such services and care. Such amounts shall be withheld pursuant to section one hundred seventy-one-f of the tax law , and shall be credited to unreimbursed medical assistance incurred on behalf of such child. The department shall by regulation establish procedures consistent with paragraphs (a) and (b) of subdivision four of section one hundred seventy-one-c of the tax law by which any individual who is the subject of a certification may contest such certification.

12. Prior to receiving medical assistance under subparagraphs five and six of paragraph (c) of subdivision one of section three hundred sixty-six of this title, a person whose net available income is at least one hundred fifty percent of the applicable federal income official poverty line, as defined and updated by the United States department of health and human services, must pay a monthly premium, in accordance with a procedure to be established by the commissioner. The amount of such premium shall be twenty-five dollars for an individual who is otherwise eligible for medical assistance under such subparagraphs, and fifty dollars for a couple, both of whom are otherwise eligible for medical assistance under such subparagraphs. No premium shall be required from a person whose net available income is less than one hundred fifty percent of the applicable federal income official poverty line, as defined and updated by the United States department of health and human services.

Title 10. Department of Health
Chapter II. Administrative Rules and Regulations
Subchapter L. Hospitals and Related Facilities
Part 85. Medical Assistance Benefits

Prior Approval for Care and Services

85.37 Time limits within which determinations shall be made.

(a) All decisions on requests for prior approval must be made and all required notices shall be sent by the New York State Department of Health to the requesting provider and, where required, to the medical assistance patient-recipient, within 21 calendar days of receipt of such requests by the New York State Department of Health; except that in cases where prior approval requests for dental care are received in area offices outside the five boroughs of New York City and a clinic examination is necessary, the required notices above shall be transmitted within 30 calendar days of receipt of such requests by the respective upstate area office.

(b) In the event prior approval requests must be returned to the requesting provider for submission of additional information, the calendar day limit in subdivision (a) of this section will be tolled from the day the request is returned to the provider until the day the request plus additional information is returned to the New York State Department of Health.

(c) In the event the prior approval request and the requested additional information from the provider is received on a Thursday or Friday which occurs after the 19th calendar day referenced in subdivision (b) of this section, two additional working days may be added to the 21-calendar day limit specified in subdivision (a) of this section.

(d) If a determination is not made and transmitted in accordance with provisions in subdivisions (a)-(c) of this section, the New York State Department of Health shall, within two working days from the expiration of the time limits set forth in subdivisions (a)-(c) of this section, notify the requesting provider and patient-recipient of such fact and of the patient's-recipient's right to request a fair hearing to determine whether the prior approval request should be approved.

Title 18. Department of Social Services
Chapter II. Regulations of the Department of Social Services
Subchapter B. Public Assistance
Article 2. Determination of Eligibility – Categorical
Part 360. Medical Assistance
Subpart 360-4. Financial Eligibility

360-4.8 Determination of financial eligibility; effect of excess income and resources on eligibility.

(a) Financial eligibility.

(1) Except as provided in paragraphs (2), (3), (4) and (5) of this subdivision, an applicant/recipient is financially eligible for MA if his or her net available income and net available resources do not exceed the appropriate standards. The standards are found in section 360-4.7 of this Subpart.
(2)
(i) A pregnant woman is financially eligible for MA if her net available income does not exceed the highest of the following three items: the applicable MA standard; the applicable PA standard of need; or 100 percent of the applicable poverty line listed in section 360-4.7(b) of this Subpart.
(ii) A pregnant woman is financially eligible for comprehensive prenatal care services available under the Prenatal Care Assistance Program, as listed in Public Health Law, section 2522, if her net available income exceeds the highest of the three items listed in subparagraph (i) of this paragraph but does not exceed 185 percent of the applicable poverty line listed in section 360-4.7(b) of this Subpart.
(3) An infant younger than one year of age is financially eligible for MA if his or her net available household income does not exceed 185 percent of the applicable Federal poverty line set forth in section 360-4.7(b) of this Subpart.
(4) A child at least one year of age but younger than six years of age is financially eligible for MA if his or her net available household income does not exceed 133 percent of the applicable Federal poverty line set forth in section 360-47(b) of this Subpart.
(5) A child born after September 30, 1983 who is at least six years of age but younger than 19 years of age is financially eligible for MA if his or her net available household income does not exceed 100 percent of the applicable Federal poverty line set forth in section 360-4.7(b) of this Subpart.
(6) Applicants/recipients who are financially eligible under paragraphs (1) through (5) of this subdivision will be authorized to receive MA if they also meet the nonfinancial eligibility requirements. The nonfinancial eligibility requirements are found in Subpart 360-3 of this Part.

(b) Reduction of excess resources.

An MA applicant/recipient whose net available resources exceed the resource standards will be ineligible for MA until he/she incurs medical expenses equal to or greater than the excess

resources. However, nonexempt resources transferred for less than their fair market value may still be considered available, under section 360-4.4(c) of this Subpart.

(c) Reduction of excess income.

(1) Except as provided in paragraphs (4) and (5) of this subdivision, if an otherwise eligible MA applicant's or recipient's net available income exceeds the appropriate income standard, he or she will be eligible for MA only after incurring medical expenses equal to or greater than the amount of excess income, provided such medical expenses are not subject to payment by a third party other than another public program of the State or any of its political subdivisions. Once deduction of incurred medical expenses reduces income to the income standard, the MA applicant or recipient is eligible for MA; however, no MA payment will be made for those incurred medical expenses used to establish eligibility. The social services district will deduct from the MA applicant's income the following medical expenses incurred by the applicant, by family members living with the applicant for whom the applicant is legally responsible, and by legally responsible relatives living with the applicant, in the order listed below and regardless of whether these expenses are subject to payment by another public program of the State or any of its political subdivisions:
(i) expenses incurred for Medicare and other health insurance premiums, deductibles, or coinsurance charges;
(ii) expenses incurred for necessary medical and remedial services that are recognized under State law but are not covered by MA; and
(iii) expenses incurred for necessary medical and remedial services that are covered under the MA program.
(2) Budgeting periods.
(i) To be eligible for MA coverage for acute care in a medical facility, an applicant/recipient must incur medical expenses equal to or greater than the amount of his/her excess income for a period of six months. Once that amount of medical expenses has been incurred, the applicant/recipient may receive full MA coverage for a period of six months.
(ii) To be eligible for MA coverage of all medical care, services and supplies outside the medical facility, as well as prosthetic appliances (including dentures), the applicant/recipient must incur medical expenses in the month equal to or greater than the amount of his/her excess monthly income. When that amount of medical expenses has been incurred, the applicant/recipient will receive MA outpatient coverage for any additional medical expenses incurred in that month.
(iii) If an MA recipient regularly receives home care in the community but is temporarily absent from the home to receive respite care for a fixed period of up to four weeks in an intermediate care facility, skilled nursing facility, or residential health care facility, he/she will be eligible for MA coverage of the respite care for each month in which incurred medical expenses are at least equal to the amount of monthly excess income. Respite care is infrequent and temporary substitute care or supervision provided to a person on behalf of and in the absence of the caregiver, in order to relieve the caregiver from the stresses or responsibilities of providing constant care and to enable the caregiver to maintain a normal routine. Respite care must be provided in accordance with the terms of approved Federal waivers.
(3) For services regularly requiring prior approval, after the social services district tells the recipient the amount of services that are medically necessary for him/her, as determined by the district according to applicable regulations, additional medical services over and above the

amount which is medically necessary cannot be used to reduce the amount of the recipient's excess income.
(4) Except as provided in paragraph (5) of this subdivision, a social services district will authorize MA for an otherwise eligible MA applicant or recipient who pays to the district the amount that his or her net available income exceeds the appropriate income standard, provided that the district submits to the department and receives approval of a plan for the pre-payment of excess income.
(i) A plan for the pre-payment of excess income must provide that:
(a) the MA applicant or recipient has the option of participating in the pre-payment program;
(b) the MA applicant or recipient must pay to the social services district the amount that his or her net available income exceeds the appropriate income standard for the budgeting period specified in paragraph (2) of this subdivision, minus the amount of any medical expenses incurred during the budgeting period or credited pursuant to subparagraph (iii) of this paragraph which are not payable by the MA program;
(c) the social services district must safeguard the amounts paid to it by an MA recipient who participates in the pre-payment program by depositing such amounts in a special pre-payment account.
(d) the social services district must periodically reconcile the amount in the MA recipient's pre-payment account with the amount of MA payments made on his or her behalf for the budgeting period specified in paragraph (2) of this subdivision to determine if a refund to the MA recipient or credit to the MA recipient's pre-payment account for subsequent spenddown period(s) is appropriate; and
(e) the social services district must report to the department the pre-payment amounts collected minus any refunds made pursuant to subparagraph (iii) of this paragraph.
(ii) A plan for the pre-payment of excess income must include a detailed description of how the social services district will:
(a) administer the pre-payment program;
(b) enroll MA applicants and recipients; and
(c) meet the requirements of subparagraphs (i) and (iii) of this paragraph.
(iii) Refunds and credits.
(a) If an MA recipient makes a payment pursuant to this paragraph and then incurs medical expenses during the budgeting period that are not payable by MA, the social services district must:
(1) prefund to the MA recipient the amount of such medical expenses from the recipient's pre-payment account for that budgeting period. If the amount of such medical expenses exceeds the MA recipient's pre-payment account for that budgeting period, the district must credit the remainder to the MA recipient's pre-payment account for the subsequent spenddown period(s); or
(2) credit the amount of such medical expenses to the MA recipient's pre-payment account for the subsequent spenddown period(s).
A plan for the pre-payment of excess income may provide for the social services district to make this refund separately as described in this clause or as part of the periodic refund described in clause (*b*) of this subparagraph.
(b) The social services district will periodically compare the amount in the MA recipient's pre-payment account, minus any amount to be refunded for medical expenses which are not payable by MA, to the amount of MA payments made on his or her behalf for the budgeting

period specified in paragraph (2) of this subdivision. If the former exceeds the latter, the social services district must periodically refund the difference to the MA recipient or credit the difference to the recipient's pre-payment account for the subsequent spenddown period(s).
(iv) When a social services district submits a pre-payment plan for excess income to the department for approval, the department will approve, disapprove, or request the social services district to modify such plan within 90 days of receipt of the plan.
(5)
(i) Federally nonparticipating persons described in section 360-3.3(b)(7) of this Part whose net available income exceeds the appropriate income standard cannot become eligible for MA by incurring medical expenses equal to or greater than the amount of their excess income.
(ii)
(a) A pregnant woman whose net available income exceeds 185 percent of the applicable poverty line listed in section 360-4.7(b) of this Subpart:
(1) cannot become eligible for comprehensive prenatal care services listed in section 2522 of the Public Health Law by incurring medical expenses equal to or greater than the amount by which her net available income exceeds 185 percent of such line; and
(2) cannot become eligible for full MA coverage by incurring medical expenses equal to or greater than the amount by which her net available income exceeds 100 percent of such line.
(b) A pregnant woman whose net available income exceeds 100 percent of the applicable poverty line listed in section 360-4.7(b) of this Subpart but does not exceed 185 percent of such line cannot become eligible for full MA coverage by incurring medical expenses equal to or greater than the amount by which her net available income exceeds 100 percent of such line.
(c) An infant younger than one year of age whose net available income exceeds 185 percent of the applicable poverty line listed in section 360-4.7(b) of this Subpart cannot become eligible for MA by incurring medical expenses equal to or greater than the amount by which his or her net available income exceeds 185 percent of such line.
(iii) A child at least one year of age but younger than six years of age whose net available household income exceeds 133 percent of the applicable Federal poverty line set forth in section 360-4.7(b) of this Subpart cannot become eligible for MA coverage by incurring medical expenses equal to or greater than the amount by which his or her net available household income exceeds 133 percent of such poverty line.
(iv) A child born after September 30, 1983 who is at least six years of age but younger than 19 years of age whose net available household exceeds 100 percent of the applicable Federal poverty line set forth in section 360-4.7(b) of this Subpart cannot become eligible for MA by incurring medical expenses equal to or greater than the amount by which his or her net available household income exceeds 100 percent of such poverty line.
(v) A pregnant woman or child described in subparagraph (ii), (iii) or (iv) of this paragraph can become eligible for full MA coverage only by incurring medical expenses equal to or greater than the amount by which his or her net available household income exceeds the higher of the applicable MA standard or PA standard of need.

Title 18. Department of Social Services
Chapter II. Regulations of the Department of Social Services
Subchapter E. Medical Care
Article 3. Policies and Standards Governing Provision of Medical and Dental Care
Part 506. Dental Care

506.3 Authorization for dental services and supplies.

(a) Identification card as authorization.
The identification card issued to persons eligible for medical assistance shall constitute full authorization for providing any of the following dental services and supplies and no special or prior authorization shall be required therefor:
(1) dental services required for emergency care and/or the relief of pain or acute infection;
(2) oral examination, including treatment plan, if necessary;
(3) periapical, bitewing, occlusal and extraoral radiograps, as required;
(4) oral propylaxis, including cleaning, supra and subgingival scaling and polishing of teeth;
(5) topical fluoride applications for persons 13 years of age and under;
(6) restoration of carious permanent and primary teeth with:
(i) silver amalgam;
(ii) silicate cement;
(iii) plastic materials;
(iv) stainless steel crowns when supported by adequate justification;
(7) pulpotomy for permanent or primary teeth;
(8) endodontic therapy for incisor or cuspid teeth; however, prior authorization shall be required if complete endodontic therapy is required for more than one tooth, or if a crown is required to supplement endodontic therapy on one or more teeth;
(9) extraction of infected or nonrestorable teeth; however, prior authorization shall be required if one or more extractions will require the construction of a dental prosthetic appliance to alleviate a serious health condition or one which affects employability;
(10) repair of full or partial dentures, recementing crowns and fixed bridges, or replacing facings on bridges.

(b) Prior approval and prior authorization required.
In addition to the medical assistance identification card, prior approval of the dental director and prior authorization of the social services official shall be required for the following:
(1) all preventive, prophylactic, and other routine dental care, services, treatment and supplies not specifically set forth in subdivision (a) of this section;
(2) all dental prosthetic appliances which shall be furnished only if required to alleviate a serious health condition including one which affects employability.
(c) The provisions of this section shall apply to all dental services and supplies provided to eligible applicants for and recipients of medical assistance on and after July 1, 1969.

Title 18. Department of Social Services
Chapter II. Regulations of the Department of Social Services
Subchapter E. Medical Care
Article 5. Procedure and Forms
Part 540. Authorization of Medical Care

540.6 Billing for medical assistance.

(a)

(1) Claims for payment for medical care, services or supplies furnished by any provider under the medical assistance program must be initially submitted within 90 days of the date the medical care, services or supplies were furnished to an eligible person to be valid and enforceable against the department or a social services district, unless the provider's submission of the claims is delayed beyond 90 days due to circumstances outside of the control of the provider. Such circumstances include but are not limited to attempts to recover from a third party insurer, legal proceedings against a responsible third-party or the recipient of the medical care, services or supplies or delays in the determination of client eligibility by the social services district. All claims submitted after 90 days must be accompanied by a statement of the reason for such delay and must be submitted within 30 days from the time submission came within the control of the provider, subject to the limitations of paragraph (3) of this subdivision.
(2) Any claim returned to a provider due to data insufficiency or claiming errors may be resubmitted by the provider upon proper completion of the claim in accordance with the claims processing requirements of the department within 60 days of the date of the notification to the provider advising the provider of such insufficiency or invalidity. Any returned claim not correctly resubmitted within 60 days or on the second resubmission is neither valid nor enforceable against the department or a social services district.
(3) Notwithstanding paragraphs (1) and (2) of this subdivision to the contrary:
(i) all claims for payment for medical care, services or supplies furnished by non-public providers under the medical assistance program must be finally submitted to the department or its fiscal agent and be payable within two years from the date the care, services or supplies were furnished in order to be valid and enforceable as against the department or a social services district; and
(ii) all claims for payment for medical care, services or supplies furnished by public providers must be finally submitted to the department or its fiscal agent and be payable within two years from the date the care, services or supplies were furnished (or within such other period as agreed by the department and the public provider for payments initially made by the public provider under a program other than the medical assistance program) in order to be valid and enforceable as against the department or a social service district.
(4) For purposes of this subdivision, a claim is considered submitted upon its receipt by the department or its fiscal agent.

(e)

(1) As a condition of payment, all providers of medical assistance must take reasonable measures to ascertain the legal liability of third parties to pay for medical care and services.
(2) No claim for reimbursement shall be submitted unless the provider has:
(i) investigated to find third-party resources in the same manner and to the same extent as the provider would to ascertain the existence of third-party resources for individuals for whom reimbursement is not available under the medical assistance program; and
(ii) sought reimbursement from liable third parties.
(3) Each medical assistance provider shall:
(i) request the medical assistance recipient or his representatives to inform the provider of any resources available to pay for medical care and services;
(ii) make claims against all resources indicated on a Medicaid identification card or communicated to the provider via the electronic Medicaid eligibility verification system, via the medical assistance information and payment system (MMIS) toll-free inquiry telephone number of via the MMIS transaction telephone system, and all resources which the provider has discovered, prior to submission of any claim to the medical assistance program;
(iii) continue investigation and attempts to recover from potential third-party resources after submission of a claim to the medical assistance program to at least the same extent that such investigations and attempts would occur in the absence of reimbursement by the medical assistance program;
(iv) if the provider is informed of the potential existence of any third-party resources by an official of the medical assistance program, or by any other person who can reasonably be presumed to have knowledge of a probable source of third-party resources, investigate the possibility of making a claim to the liable third party and make such claim as is reasonably appropriate; and
(v) take any other reasonable measures necessary to assure that no claims are submitted to the medical assistance program that could be submitted to another source of reimbursement.
(4) Any reimbursement the provider recovers from liable third parties shall be applied to reduce any claims for medical assistance submitted for payment to the medical assistance program by such provider or shall be repaid to the medical assistance program within 30 days after third-party liability has been ascertained; when a claim has been submitted to a third party whose liability was ascertained after submission of a claim to the medical assistance program the provider must make reimbursement to the medical assistance program within 30 days after the receipt of reimbursement by the provider from a liable third party.
(5) A provider of medical assistance shall not deny care or services to a medical assistance recipient because of the existence of a third-party resource to which a claim for payment may be submitted in accordance with this subdivision.
(6) A provider of medical assistance must review and examine information relating to available health insurance and other potential third-party resources for each medical assistance recipient to determine if a health insurance identification card or any other information indicates that prior or other approval is required for nonemergency, post-emergency, nonmaternity, hospital, physician or other medical care, services or supplies. If approval is required as a condition of payment or reimbursement by an insurance carrier or other liable third party, the provider must obtain for the recipient, or ensure that the recipient has obtained, any necessary approval prior to submitting any claims for reimbursement from the medical assistance program. The provider must comply with all Medicare or other third-party billing requirements

and must accept assignment of the recipient's right to receive payment or must acquire any other rights of the recipient necessary to ensure that no reimbursement is made by the medical assistance program when the costs of medical care, services or supplies could be borne by a liable third party. If a provider fails to comply with these conditions, any reimbursement received from the medical assistance program in violation of the provisions of this paragraph must be repaid to the medical assistance program by such provider. No repayment will be required if the provider can produce acceptable documentation to the department that the provider reasonably attempted to ascertain and satisfy any conditions of approval or other claiming requirements of liable third-party payors in the same manner and to the same extent as the provider would for individuals for whom reimbursement is not available under the medical assistance program, as described in paragraphs (1) through (5) of this subdivision,.
(7) A provider of medical assistance who becomes aware, or reasonably should have become aware, of available health insurance or other potential third party resources that can be claimed from a liable third party by the provider as an agent of a social services official in accordance with the provisions of Part 542 of this Title, must submit a claim for such payment to the liable third party in the manner described in Part 542, except that a provider will not be required to submit such a claim to a liable third party when the claim is for prenatal care for pregnant women or preventive pediatric services (including early and periodic screening, diagnosis and treatment services). If a provider fails to submit such a claim as required by this paragraph, reimbursement for such claim will not be made by the medical assistance program and any reimbursement received in violation of the provisions of this paragraph must be repaid to the medical assistance program by such provider. If a provider has satisfied the requirements described in paragraphs (1) through (6) of this subdivision, no repayment will be required if the provider can produce documentation acceptable to the department that the provider reasonably attempted to ascertain whether such claim could be submitted in the manner described in Part 542 of this Title. If a provider submits a claim in accordance with the provisions of Part 542 of this Title and all or a portion of such claim is rejected by the liable third party through no fault of the provider, that portion of the claim that is so rejected may be submitted to the medical assistance program for payment.

Title 42. Public Health
Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services
Subchapter C. Medical Assistance Programs
Part 435. Eligibility in the States, District of Columbia, the Northern Mariana Islands, and American Samoa
Subpart J. Eligibility in the States and District of Columbia

435.956 Verification of other non-financial information.

(a)*Citizenship and immigration status.* (1)(i) The agency must -

(A) Verify citizenship status through the electronic service established in accordance with § 435.949 or alternative mechanism authorized in accordance with § 435.945(k), if available; and

(B) Promptly attempt to resolve any inconsistencies, including typographical or other clerical errors, between information provided by the individual and information from an electronic data source, and resubmit corrected information through such electronic service or alternative mechanism.

(ii) If the agency is unable to verify citizenship status in accordance with paragraph (a)(1)(i) of this section, the agency must verify citizenship either -

(A) Through a data match with the Social Security Administration; or

(B) In accordance with § 435.407.

(2) The agency must -

(i) Verify immigration status through the electronic service established in accordance with § 435.949, or alternative mechanism authorized in accordance with § 435.945(k);

(ii) Promptly attempt to resolve any inconsistencies, including typographical or other clerical errors, between information provided by the individual and information from an electronic data source, and resubmit corrected information through such electronic service or alternative mechanism.

(3) For purposes of the exemption from the five-year waiting period described in 8 U.S.C. 1613, the agency must verify that an individual is an honorably discharged veteran or in active military duty status, or the spouse or unmarried dependent child of such person, as described in 8 U.S.C. 1612(b)(2) through the electronic service described in § 435.949 or alternative mechanism authorized in accordance with § 435.945(k). If the agency is unable to verify such status through such service the agency may accept self-attestation of such status.

(4)

(i) The agency must maintain a record of having verified citizenship or immigration status for each individual, in a case record or electronic database in accordance with the State's record retention policies in accordance with § 431.17(c) of this chapter.

(ii) Unless the individual reports a change in citizenship or the agency has received information indicating a potential change in the individual's citizenship, the agency may not re-verify or require an individual to re-verify citizenship at a renewal of eligibility under § 435.916 of this subpart, or upon a subsequent application following a break in coverage.

(5) If the agency cannot promptly verify the citizenship or satisfactory immigration status of an individual in accordance with paragraph (a)(1) or (2) of this section, the agency -

(i) Must provide a reasonable opportunity in accordance with paragraph (b) of this section; and

(ii) May not delay, deny, reduce or terminate benefits for an individual whom the agency determines to be otherwise eligible for Medicaid during such reasonable opportunity period, in accordance with § 435.911(c).

(iii) If a reasonable opportunity period is provided, the agency may begin to furnish benefits to otherwise eligible individuals, effective the date of application, or the first day of the month of application, consistent with the agency's election under § 435.915(b).

(b)*Reasonable opportunity period.*

(1) The agency must provide a reasonable opportunity period to individuals who have made a declaration of citizenship or satisfactory immigration status in accordance with § 435.406(a), and for whom the agency is unable to verify citizenship or satisfactory immigration status in accordance with paragraph (a)of this section. During the reasonable opportunity period, the agency must continue efforts to complete verification of the individual's citizenship or satisfactory immigration status, or request documentation if necessary. The agency must provide notice of such opportunity that is accessible to persons who have limited English proficiency and individuals with disabilities, consistent with § 435.905(b). During such reasonable opportunity period, the agency must, if relevant to verification of the individual's citizenship or satisfactory immigration status -

(i) In the case of individuals declaring citizenship who do not have an SSN at the time of such declaration, assist the individual in obtaining an SSN in accordance with § 435.910, and attempt to verify the individual's citizenship in accordance with paragraph (a)(1) of this section once an SSN has been obtained and verified;

(ii) Promptly provide the individual with information on how to contact the electronic data source described in paragraph (a) of this section so that he or she can attempt to resolve any inconsistencies defeating electronic verification directly with such source, and pursue verification of the individual's citizenship or satisfactory immigration status if the individual or source informs the agency that the inconsistencies have been resolved; and

(iii) Provide the individual with an opportunity to provide other documentation of citizenship or satisfactory immigration status, in accordance with section 1137(d) of the Act and § 435.406 or§ 435.407.

(2) The reasonable opportunity period -

(i) Begins on the date on which the notice described in paragraph (b)(1) of this section is received by the individual. The date on which the notice is received is considered to be 5 days after the date on the notice, unless the individual shows that he or she did not receive the notice within the 5-day period.

(ii)

(A) Ends on the earlier of the date the agency verifies the individual's citizenship or satisfactory immigration status or determines that the individual did not verify his or her citizenship or satisfactory immigration status in accordance with paragraph (a)(2) of this section, or 90 days after the date described in paragraph (b)(2)(i) of this section, except that,

(B) The agency may extend the reasonable opportunity period beyond 90 days for individuals declaring to be in a satisfactory immigration status if the agency determines that the individual is making a good faith effort to obtain any necessary documentation or the agency needs more time to verify the individual's status through other available electronic data sources or to assist the individual in obtaining documents needed to verify his or her status.

(3) If, by the end of the reasonable opportunity period, the individual's citizenship or satisfactory immigration status has not been verified in accordance with paragraph (a) of this section, the agency must take action within 30 days to terminate eligibility in accordance with part 431 subpart E (relating to notice and appeal rights) of this chapter, except that §§ 431.230 and 431.231 of this chapter (relating to maintaining and reinstating services) may be applied at State option.

(4)

(i) The agency may establish in its State plan reasonable limits on the number of reasonable opportunity periods during which medical assistance is furnished which a given individual may receive once denied eligibility for Medicaid due to failure to verify citizenship or satisfactory immigration status, provided that the conditions in paragraph (b)(4)(ii) of this section are met.

(ii) Prior to implementing any limits under paragraph (b)(4)(i) of this section, the agency must -

(A) Demonstrate that the lack of limits jeopardizes program integrity; and

(B) Receive approval of a State plan amendment prior to implementing limits.

(c)*State residency.*

(1) The agency may verify State residency in accordance with § 435.945(a) of this subpart or through other reasonable verification procedures consistent with the requirements in § 435.952 of this subpart.

(2) Evidence of immigration status may not be used to determine that an individual is not a State resident.

(d)*Social Security numbers.* The agency must verify Social Security numbers (SSNs) in accordance with § 435.910 of this subpart.

(e)*Pregnancy.* The agency must accept self-attestation of pregnancy unless the State has information that is not reasonably compatible with such attestation, subject to the requirements of § 435.952 of this subpart.

(f)*Age, date of birth and household size.* The agency may verify date of birth and the individuals that comprise an individual's household, as defined in § 435.603(f) of this part, in accordance with § 435.945(a) of this subpart or through other reasonable verification procedures consistent with the requirements in § 435.952 of this subpart.

15. ACCESS REQUIREMENTS

15.1 General Requirement

The Contractor will establish and implement mechanisms to ensure that Participating Providers comply with timely access requirements, monitor regularly to determine compliance and take corrective action if there is a failure to comply.

15.2 Appointment Availability Standards

a) The Contractor shall comply with the following minimum appointment availability standards, as applicable.

i) For emergency care: immediately upon presentation at a service delivery site.
ii) For CPEP, inpatient mental health and Inpatient Detoxification Substance Use Disorder services and Crisis Intervention services: immediately upon presentation at a service delivery site.
iii) For urgent care: within twenty-four (24) hours of request.
iv) For urgently needed Substance Use Disorder inpatient rehabilitation services, stabilization treatment services in OASAS certified residential settings and mental health or Substance Use Disorder outpatient clinics, Assertive Community Treatment (ACT), Personalized Recovery Oriented Services (PROS) and Opioid Treatment Programs: within twenty-four (24) hours of request.
v) Non-urgent “sick” visit: within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated.
vi) Routine non-urgent, preventive appointments except as otherwise provided in this Section: within four (4) weeks of request.
vii)Specialist referrals (not urgent), except as otherwise provided in this Section: within four (4) to six (6) weeks of request.
viii) Behavioral health specialist referrals (not urgent):
A) For Continuing Day Treatment, Intensive Psychiatric Rehabilitation Treatment programs and Rehabilitation services for residential Substance Use Disorder treatment services: within two (2) to (4) weeks of request; and
B) For PROS programs other than clinic services: within two (2) weeks of request.
ix) Initial prenatal visit: within three (3) weeks during first trimester, within two (2) weeks during the second trimester and within one (1) week during the third trimester.
x) Adult Baseline and routine physicals: within twelve (12) weeks from enrollment. (Adults >21 years). [Applicable to HIV SNP Program only]: Adult Baseline and routine physicals: within four (4) weeks from enrollment. (Adults >21 years).
xi) Well child care: within four (4) weeks of request.
xii)Initial family planning visits: within two (2) weeks of request.
xiii) Pursuant to an emergency hospital discharge or release from incarceration, where the Contractor is informed of such release, mental health or Substance Use Disorder

follow-up visits with a Participating Provider (as included in the Benefit Package): within five (5) days of request, or as clinically indicated.

xiv) Non-urgent mental health or Substance Use Disorder visits with a Participating Provider that is a Mental Health and/or Substance Use Disorder Out Patient Clinic, including a PROS clinic: within one(1) week of request.
xv) Initial PCP office visit for newborns: within two (2) weeks of hospital discharge; [Applicable to HIV SNP Program only]: Initial PCP office visit for newborns within forty-eight (48) hours of hospital discharge or the following Monday if the discharge occurs on a Friday.
xvi) Provider visits to make health, mental health and substance abuse assessments for the purpose of making recommendations regarding a recipient's ability to perform work when requested by a LDSS: within ten (10) days of request by an MMC Enrollee, in accordance with Section 10.7 of this Agreement.
xvii) Appointment availability standards for Behavioral Health Home and Community Based Services are outlined in Appendix T: Additional Requirements for HARP and HIV SNP Programs.

15.3 Twenty-Four (24) Hour Access

a) The Contractor must provide access to medical services and coverage to Enrollees, either directly or through their PCPs and OB/GYNs, on a twentyfour (24) hour a day, seven (7) day a week basis. The Contractor must instruct Enrollees on what to do to obtain services after business hours and on weekends.

b) The Contractor may satisfy the requirement in Section 15.3(a) by requiring their PCPs and OB/GYNs to have primary responsibility for serving as after hours "on-call" telephone resource to members with medical problems. Under no circumstances may the Contractor routinely refer calls to an emergency room.

15.4 Appointment Waiting Times

a) Enrollees with appointments shall not routinely be made to wait longer than one hour.

b) [Applicable to HIV SNP Program only]: The Contractor shall be responsible for ensuring network providers have policies and procedures addressing Enrollees, and in particular adolescents and persons presenting with a behavioral health condition, who present for unscheduled, non-urgent care with the aim of promoting Enrollee access to appropriate care.

c) [Applicable to the HARP Program only]: The Contractor shall be responsible for ensuring network providers have policies and procedures addressing Enrollees who present for unscheduled, non-urgent care with the aim of promoting Enrollee access to appropriate care.

15.5 Travel Time Standards

a) The Contractor will maintain a network that is geographically accessible to the population to be served.

b) Primary Care

i) Travel time/distance to primary care sites shall not exceed thirty (30) minutes from the Enrollee's residence in metropolitan areas or thirty (30) minutes/thirty (30) miles from the Enrollee's residence in nonmetropolitan areas. Transport time and distance in rural areas to primary care sites may be greater than thirty (30) minutes/thirty (30) miles from the Enrollee's residence if based on the community standard for accessing care or if by Enrollee choice. Applicable to HIV SNP Program only, travel time to HIV Specialist PCP sites shall not exceed thirty (30) minutes except that in certain counties identified by the AIDS Institute, based on the community standard for accessing HIV specialist care, travel time shall not exceed thirty (30) minutes/thirty (30) miles.

ii) Enrollees may, at their discretion, select participating PCPs located farther from their homes as long as they are able to arrange and pay for transportation to the PCP themselves. In the case of a Restricted Enrollee as described in Appendix Q of this Agreement, the Contractor may allow the Restricted Enrollee to select an RRP PCP provider further from their home as long as they are able to arrange and pay for transportation to the RRP PCP Provider themselves.

iii) Contractors that cover non-emergency transportation services in the Prepaid Benefit Package shall inform their Enrollees, in writing, of the Enrollee's responsibility to arrange and pay for transportation to their PCP if the Enrollee selects a participating PCP outside of the time and distance standards.

c) Other Providers Travel time/distance to specialty care, hospitals, mental health, lab and x-ray providers shall not exceed thirty (30) minutes/thirty (30) miles from the Enrollee's residence. Transport time and distance in rural areas to specialty care, hospitals, mental health, lab and x-ray providers may be greater than thirty (30) minutes/thirty (30) miles from the Enrollee's residence if based on the community standard for accessing care or if by Enrollee choice.

15.6 Service Continuation

a) New Enrollees

i) If a new Enrollee has an existing relationship with a health care provider who is not a member of the Contractor's provider network, the Contractor shall permit the Enrollee to continue an ongoing course of treatment by the Non-Participating Provider during a transitional period of up to sixty (60) days from the Effective Date of Enrollment if the Enrollee has a life-threatening disease or condition or a degenerative and disabling disease or condition.

ii) If the Enrollee has entered the second trimester of pregnancy at the Effective Date of Enrollment, the transitional period shall continue for the remainder of the pregnancy, including delivery and the provision of postpartum care directly related to the delivery up to sixty (60) days after the delivery.

iii) If the new Enrollee elects to continue to receive care from such Non-Participating Provider, such care shall be authorized by the Contractor for the transitional period only if the Non-Participating Provider agrees to:

A) accept reimbursement from the Contractor at rates established by the Contractor as payment in full, which rates shall be no more than the level of reimbursement applicable to similar providers within the Contractor's network for such services; and

B) adhere to the Contractor's quality assurance requirements and agrees to provide to the Contractor necessary medical information related to such care; and

C) otherwise adhere to the Contractor's policies and procedures including, but not limited to procedures regarding referrals and obtaining pre-authorization in a treatment plan approved by the Contractor.

iv) In no event shall this requirement be construed to require the Contractor to provide coverage for benefits not otherwise covered.

b) Enrollees Whose Health Care Provider Leaves Network

i) The Contractor shall permit an Enrollee, whose health care provider has left the Contractor's network of providers, for reasons other than imminent harm to patient care, a determination of fraud or a final disciplinary action by a state licensing board that impairs the health professional's ability to practice, to continue an ongoing course of treatment with the Enrollee's current health care provider during a transitional period, consistent with PHL § 4403(6)(e).

ii) The transitional period shall continue up to ninety (90) days from the date the provider's contractual obligation to provide services to the Contractor's Enrollees terminates; or, if the Enrollee has entered the second trimester of pregnancy, for a transitional period that includes the provision of post-partum care directly related to the delivery through sixty (60) days post partum. If the Enrollee elects to continue to receive care from such Non-Participating Provider, such care shall be authorized by the Contractor for the transitional period only if the Non-Participating Provider agrees to:

A) accept reimbursement from the Contractor at rates established by the Contractor as payment in full, which rates shall be no more than the level of reimbursement applicable to similar providers within the Contractor's network for such services;

B) adhere to the Contractor's quality assurance requirements and agrees to provide to the Contractor necessary medical information related to such care; and

C) otherwise adhere to the Contractor's policies and procedures including, but not limited to procedures regarding referrals and obtaining pre-authorization in a treatment plan approved by the Contractor.

iii) In no event shall this requirement be construed to require the Contractor to provide coverage for benefits not otherwise covered.

iv) In accordance with Section 21.10 of this Agreement, the Contractor shall notify impacted Enrollees whose health care provider has left the Contractor's network.

15.7 Standing Referrals

The Contractor will implement policies and procedures to allow for standing referrals to specialist physicians for Enrollees who have ongoing needs for care from such specialists, consistent with PHL § 4403(6)(b).

15.8 Specialist as a Coordinator of Primary Care

a) The Contractor will implement policies and procedures to allow Enrollees with a life-threatening or degenerative and disabling disease or condition, which requires prolonged specialized medical care, to receive a referral to a specialist, who will then function as the coordinator of primary and specialty care for that Enrollee, consistent with PHL § 4403(6)(c).

b) [Applicable to HIV SNP Program only]: If the specialist does not meet the qualifications of an HIV Specialist, and the Enrollee is HIV infected, then a co-management model must be employed in which an HIV Specialist assists the PCP in an ongoing consultative relationship as part of routine care and continues with primary responsibility for decisions related to HIV-specific clinical management in coordinating with the other specialist.

15.9 Specialty Care Centers

The Contractor will implement policies and procedures to allow Enrollees with a life-threatening or a degenerative and disabling condition or disease, which requires prolonged specialized medical care to receive a referral to an accredited or designated specialty care center with expertise in treating the life-threatening or degenerative and disabling disease or condition, consistent with PHL § 4403(6)(d).

15.10 Cultural and Linguistic Competence

a) The Contractor shall promote and ensure the delivery of services in a culturally competent manner to all Enrollees, including but not limited to those with limited English proficiency and diverse cultural and ethnic backgrounds as well as Enrollees with diverse sexual orientations, gender identities and member of diverse faith communities. For the purpose of this Agreement, cultural competence means having the capacity to function effectively within the context of the

cultural beliefs, behaviors, and needs presented by Enrollees and their communities across all levels of the Contractor's organization.

b) In order to comply with this section, the Contractor shall:

i) Maintain an inclusive, culturally competent provider network, as provided in Section 21 of this Agreement, including culturally competent network of Behavioral Health Providers, individual behavioral health practitioners, community-based providers and peer-delivered services;

ii) Adopt policies and procedures that incorporate the importance of honoring Enrollees' beliefs, sensitivity to cultural diversity, fostering respect for Enrollees' culture and cultural identity, and eliminating cultural disparities;

iii) Maintain a Cultural Competence component of the Contractor's Internal Quality Assurance program referenced in Section 16.1 (d) of this Agreement;

iv) Develop and execute a comprehensive cultural competence plan based on Culturally and Linguistically Appropriate Services (CLAS) national standards of the US Department of Health and Human Services, Office of Minority Health and managed through the Contractor's Internal Quality Assurance Program;

v) Perform internal cultural competence activities including, but not limited to conducting:

A) Organization-wide cultural competence self-assessment;

B) Community needs assessments to identify threshold populations in each Service Area in which the Contractor operates; and

C) Quality improvement projects to improve cultural competence and reduce disparities, informed by such assessments and CLAS standards.

vi) Facilitate annual training in cultural competence for all the Contractor's staff members. All elements of the curriculum shall be consistent with and/or reflect CLAS national standards. The Contractor's cultural competence training materials are subject to the review and approval by the State.

c) The Contractor shall ensure the cultural competence of its provider network by requiring Participating Providers to certify, on an annual basis, completion of State-approved cultural competence training curriculum, including training on the use of interpreters, for all Participating Providers' staff who have regular and substantial contact with Enrollees. The State will provide cultural competence training materials to the Contractor and providers upon request.

15.11 Language Interpreter Services for Enrollee Encounters

a) The Contractor is required to reimburse Article 28, 31, 32 and 16 outpatient departments, hospital emergency rooms, diagnostic and treatment centers, federally qualified health centers, and office-based practitioners to provide medical language interpreter services for Enrollees

with limited English proficiency (LEP) and communication services for people who are deaf and hard of hearing.

b) An Enrollee with limited English proficiency shall be defined as an individual whose primary language is not English and who cannot speak, read, write or understand the English language at a level sufficient to permit the Enrollee to interact effectively with health care providers and their staff. The need for medical language interpreter services must be documented in the medical record.

c) Language interpreter services must be provided during scheduled appointments and scheduled encounters by a third party interpreter who is either employed by or contracts with the medical provider. These services may be provided either face-to-face, by telephone, and/or by video remote interpreter technology. The interpreter must demonstrate competency and skills in medical interpretation techniques, ethics and terminology. It is recommended, but not required, that such individuals be certified by the National Board of Certification for Medical Interpreters (NBCMI) or be qualified by New York State wherever possible.

d) The Contractor shall advise Enrollees that they are entitled to receive language interpretation services upon request and at no charge to the Enrollee.

15.12 Telehealth Health Care and Telepsychiatry Services

a) The Contractor is responsible for covering services in the benefit package that are delivered by telehealth in accordance with Section 2999-cc and 2999-dd of the Public Health Law and any implementing regulations.

b) Effective January 1, 2016, the Contractor is responsible for covering Telepsychiatry Services delivered in accordance with OMH regulations as applicable. Telepsychiatry means the use of two-way real-time interactive audio and video to provide and support clinical psychiatric care at a distance. Telepsychiatry providers are providers of mental health services licensed pursuant to Article 31 of the Mental Hygiene Law.

New York State Medicaid Managed Care Enrollee Right to Fair Hearing and Aid Continuing for Plan Service Authorization Determinations

December 15, 2017

Federal Medicaid managed care rules published in May 6, 2016 amended procedures for service authorization, appeals, fair hearings, and aid continuing. Medicaid managed care plans, including mainstream, HIV Special Needs Plans and Health and Recovery Plans, must continue to comply with requirements in NYS statute, NYS regulation, and the Medicaid Managed Care Model Contract where not superseded by federal rule, including but not limited to the provision of evidence packets, appearance at state fair hearings, and compliance with the Office of Administrative Hearings directives and decisions.

Right to Fair Hearing regarding plan services authorization determinations:

1) 42 CFR §§438.402(c)(1)(i) and 438.408(f)(1) establish that enrollees may request a state fair hearing after receiving an appeal resolution (Final Adverse Determination) that an adverse benefit determination (Initial Adverse Determination) has been upheld.

2) 42 CFR §§438.402(c)(1)(i)(A), 438.408(c)(3), and 438.408(f)(1)(i) provide that an enrollee may be deemed to have exhausted a plan's appeals process and may request a state fair hearing where notice and timeframe requirements under 42 CFR 438.408 have not been met. Deemed exhaustion applies when:

- an enrollee requests a Plan Appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from the plan;

- an enrollee requests a Plan Appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from the plan within State-specified timeframes; or

- a plan's appeal resolution or extension notice does not meet noticing requirements identified in 42 CFR §438.408.

3) 42 CFR §438.408(f)(2) provides the enrollee no less than 120 days from the date of the adverse appeal resolution (Final Adverse Determination) to request a state fair hearing.

4) Pursuant to 42 CFR §438.424(a), if OAH determines to reverse the MMC decision, and the disputed services were not provided while the appeal and hearing were pending, the plan must authorize or provide the disputed services promptly and as expeditiously as the enrollee's condition requires but no later than 72 hours from the date the plan receives the OAH fair hearing decision.

Right to Aid Continuing

Pursuant to requirements in 42 CFR §438.420, NYS Social Services Law §365-a(8), and 18 NYCRR §360-10.8, Medicaid Managed Care (MMC) enrollees may receive continuation of benefits, known as Aid Continuing (AC), under certain circumstances. Enrollees must meet filing requirements identified in 42 CFR §438.420.

The enrollee must receive notice regarding the right to AC in the timeframes required by 42 CFR §438.404(c)(1) (10 day notice, with some exceptions) when:

- The plan makes a determination to terminate, suspend, or reduce a previously authorized service during the period for which the service was approved; or

- For an enrollee in receipt of long term services and support or nursing home services (short or long term), the plan makes a determination to partially approve, terminate, suspend, or reduce level or quantity of long term services and supports or a nursing home stay (long-term or short-term) for a subsequent authorization period of such services.

NYS MMC plans are required to provide AC:

- **immediately** upon receipt of a Plan Appeal disputing the termination, suspension or reduction of a previously authorized service, filed verbally or in writing within 10 days of the date of the notice of adverse benefit determination (Initial Adverse Determination), or the effective date of the action, whichever is later, unless the enrollee indicates they do not wish their services to continue unchanged.

- **immediately** upon receipt of a Plan Appeal disputing the partial approval, termination, suspension or reduction in quantity or level of services authorized for long term services and supports or nursing home stay for a subsequent authorization period, filed verbally or in writing within 10 days of the initial adverse determination, or the effective date of the action, whichever is later, unless the enrollee indicates they do not wish their services to continue unchanged.

- **immediately** as directed by the NYS Office of Administrative Hearings (OAH). The enrollee has a right to AC when they have exhausted the plan's appeal process and have filed a request for a state fair hearing disputing a termination, suspension or reduction of a previously authorized service, or for all long term services and supports and all nursing home stays, partial approval, termination, suspension or reduction in quantity or level of services authorized for a subsequent authorization period. (The OAH may determine other circumstances warrant the provision of AC, including but not limited to a home bound individual who was denied an increase in home care services.)

The MMC plan must continue the enrollee's services provided under AC until one of the following occurs:

- the enrollee withdraws the request for aid continuing, the plan appeal or the fair hearing;
- the enrollee fails to request a fair hearing within 10 days of the plan's written adverse appeal resolution notice (Final Adverse Determination)1;
- OAH determines that the Enrollee is not entitled to aid continuing;
- OAH completes the administrative process and/or issues a fair hearing decision adverse to the Enrollee; or
- the provider order has expired, except in the case of a home bound enrollee.

Where the final resolution upon plan appeal or fair hearing is to uphold an adverse benefit determination, the enrollee may be held liable for services in accordance with 42 CFR §438.420(d).

NY Medicaid CHOICE Brochure
Guidebook for New Yorkers with Medicaid

Getting Started

Choosing your health plan and doctor is important and it's easy! Best of all, you will have a plan and a team of doctors to help you take good care of your health. Let's get started by answering some questions you may have.

Does everyone join a health plan?

Most people must join a plan. Some people have a special reason to keep regular Medicaid. Please see the section "Who Keeps Regular Medicaid."

When should I join?

It's best to join right away! Please join no later than the day on your enrollment letter. Otherwise, New York State will choose a plan for you.

What if my county offers one health plan?

You will be enrolled in that plan but it is just as important that you choose your doctor, so please contact us.

Your managed care worker or a Medicaid Choice counselor will be happy to assist you!

Joining a Health Plan

A health plan will provide your care by working with a group (network) of doctors, clinics, hospitals and pharmacies.

You will choose one of the doctors from the health plan to be your **Primary Care Provider (PCP)**. You will go to your **PCP** and the other doctors of the plan for most of your care.

Helpful tips when selecting a plan

1. Look over your list of health plans, and then call New York Medicaid Choice or your managed care worker.
2. Ask questions, like the ones on the next page. These will help you compare health plans and narrow down your choices.

"Which health plan...?"

- works with the doctors I go to now?
- has doctors nearest to where I live or work or doctors who speak my language?
- works with the clinic, hospital and pharmacy I want to use?
- offers services to help people with HIV

For answers to your questions, or to enroll, speak to a Medicaid Choice counselor or to your county's managed care worker.

Health Plan Services

Your First 90 Days

If your county offers more than one health plan choice, you have up to 90 days, starting from your first day of enrollment, to decide if you will stay with your health plan or change plans. After this 90-day period, you must stay with the plan for the next nine months.

Note: NYC residents who are living with HIV or who are transgender or qualify as homeless may transfer to an HIV Special Needs Plan at any time. Their dependent children can also transfer with them.

Basic Services:

□□Doctor visits and hospital stays
□□Regular check-ups and shots
□□Emergency care
□□Referrals to specialists when needed
□□Prescribed medicine
□□Other services, such as eye care, dental care, medical equipment, hearing aids, HIV testing and counseling

Health plans also provide:

□□Mental health services
□□Family planning services
You may go to your health plan or to a Medicaid provider for these services.

Pharmacy Services

You can go to any pharmacy that accepts your health plan card.

Your plan will inform you about its group of pharmacies and list of covered drugs (medicine).

Nursing Home Services

Health plans cover short and long-term stays in a nursing home. Your plan will cover medical supervision, 24-hour nursing care, other services and support. Permanent stays at a nursing home must be approved by the Local Department of Social Services.

Your Doctors

Your PCP or health plan will be available to you at any time of the day or night. Your PCP will provide most of your care and will get to know your medical needs.

Referrals

You will need a referral from your PCP to see a specialist and for other services. You may get a standing referral if you see the specialist often.

You will not need a referral from your PCP for the following services:

- Emergency care
- Family planning
- Vision services
- One annual mental health assessment
- One annual chemical dependence (including alcohol and drug abuse) service assessment

No referrals are necessary for mental health and chemical dependence treatment ***if*** you have SSI, SSD, are over age 65, or you have a certified disability. However, call your health plan if you need detoxification services. *(May not apply to New York City residents enrolled in an HIV Special Needs Plan.)*

Member Services Department

All health plans have a Member Services Department to answer your questions and help resolve any problems with your doctor or health care. Member Services will help those health plan members needing special accommodations or extra support, such as:

- Help with their health care appointments and forms
- Medical offices that are wheelchair accessible or that offer other accommodations
- Booklets in large print or in audio format and TTY services for people who have trouble hearing or speaking
- Case management services
- Transitional care. In some cases, plan members who are pregnant or with a chronic condition may keep seeing a doctor who does not work with the health plan for a certain period of time

Health Plan Members have certain rights, such as:

- A choice of PCPs
- An appointment within 24 hours for urgent care and within 48 to 72 hours for routine care
- Receiving a second opinion about certain medical conditions from another provider in your plan
- Have all information about your health care kept confidential
- Complain to the health plan, State Department of Health or New York Medicaid Choice
- Ask for a fair hearing if your plan has denied, stopped or reduced treatment or services you think you should get

Restricted Services

Misusing your medicine or other plan services is not allowed and will limit your services to only certain providers and pharmacies.

Problem-solving

Don’t hesitate to call the plan’s Member Services representative for help with solving a problem with your doctor or services. You may also:

- Call New York Medicaid Choice or the managed care worker at your local Social Services office.
- If you applied through the New York State of Health marketplace call **1-855-355-5777**
- Call the State Department of Health Complaint Line at **1-800-206-8125** Monday through Friday, 8:30 am to 4:30 pm
- Ask for a fair hearing Ask for a fair hearing if your plan has denied, stopped or reduced covered services you think you should have.

Other Programs

HIV Special Needs Plan

An HIV Special Needs Plan (HIV SNPs) is a Medicaid health plan that provides services to adults who are living with HIV or who are transgender or qualify as homeless. Your dependent children can also enroll in a HIV SNP with you. HIV SNPs cover all basic health care services and specialty services important to people who are living with or at risk of HIV/AIDS. The doctors, nurses and other providers who participate in an HIV SNP understand the special care needs facing people living with HIV/AIDS.

Medicaid Advantage

New Yorkers with both Medicare and Medicaid have the option of joining a Medicaid Advantage Plan. You will receive both your Medicare and Medicaid services from your Primary Care Provider (PCP) and your health plan's network of providers.

Managed Long Term Care

Managed Long Term Care Plans help people with a disability or chronic illness receive home care and other long term care services within their communities. To receive these services, you must be eligible for Medicaid or both Medicare and Medicaid, need care for more than 120 days and meet other requirements.

Who Keeps Regular Medicaid

Some New Yorkers have a special situation that allows them to stay with regular Medicaid. They are either exempt or excluded from Medicaid managed care. If any of these situations apply to you, please speak to your managed care worker or to a Medicaid Choice counselor for more information.

Who Can Stay with Regular Medicaid

- People who live in facilities for the developmentally disabled
- Residents of a long term alcohol or substance abuse program
- People who are in regular Medicaid and are being treated for a chronic medical condition for 6 months or more by a fee-for-service Medicaid specialist who is not in a Medicaid health plan. (This exemption is limited to a 6 month period and for one time only)

□□Adults in waivered programs such as Care At Home and TBI

American Indian/Alaskan Native

American Indians/Alaskan Natives may join a health plan or keep using their Medicaid card for services. If you join a health plan, you may get services from your plan's doctors or local tribal health center.

Who Must Stay with Regular Medicaid

□□People in hospice programs at the time of enrollment
□□Children or adults who live instate psychiatric or residential treatment facilities
□□People who will get Medicaid only after they spend some of their own money for medical needs (spend-down cases)
□□People with other full benefit health insurance
□□Infants living with their mothers in jail or prison
□□All Foster care children living in NYC
□□All Foster care children living in an institutional setting outside of NYC
□□Children who are blind or disabled and living apart from their parents for 30 days or more
□□People eligible for TB services only
□□People eligible for the Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal and Prostate Cancer (MCTP)

New York State of Health

The official health plan marketplace

New York State of Health is New York's new health plan marketplace. People can go to the marketplace to get affordable health insurance or learn if they qualify for Medicaid or other health programs.

If you now get Medicaid, you do not need to do anything at this time but you should know about NY State of Health.

Redesigning New York's Medicaid Program

To address underlying health care cost and quality issues in New York's Medicaid program, within days of taking office, Governor Andrew M. Cuomo created the Medicaid Redesign Team to both craft a first year Medicaid budget proposal as well as develop a multiyear reform plan. He invited key Medicaid stakeholders to the table in a spirit of collaboration to see what could be achieved collectively to change course and rein in Medicaid spending, while at the same time improving quality.

Medicaid Redesign is premised on the idea that the only way to really control costs is to improve the health of program participants. The MRT action plan launched a series of innovative solutions designed to better manage care and reward providers that help keep people healthy. This approach differs from other states, which have relied on taking away benefits from low-income people or by cutting provider payment rates as ways to cut Medicaid costs. MRT hasn't been just about cost control. The quality of care is also being improved.

More than 200 initiatives were created as a result of MRT. These initiatives will implement programmatic changes to the way health care is provided, reimbursed and managed to ensure that we are providing quality care in the most efficient manner.

DSRIP and Medicaid Redesign Team (MRT) Waiver Amendment

On April 14, 2014, Governor Andrew M. Cuomo announced that New York has finalized terms and conditions with the federal government for a groundbreaking waiver that will allow the state to reinvest $8 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms. The MRT waiver amendment will transform the state's health care system, bend the Medicaid cost curve, and ensure access to quality care for all Medicaid members.

The Medicaid 1115 waiver amendment will enable New York to fully implement the MRT action plan, facilitate innovation, lower health care costs over the long term, and save scores of essential safety net providers from financial ruin. The waiver allows the state to reinvest over a five-year period $8 billion of the $17.1 billion in federal savings generated by MRT reforms.

The waiver amendment dollars will address critical issues throughout the state and allow for comprehensive reform through a Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program will promote community-level collaborations and focus on system reform, specifically a goal to achieve a 25 percent reduction in avoidable hospital use over five years. Safety net providers will be required to collaborate to implement innovative projects focusing on system transformation, clinical improvement and population health improvement. Single providers will be ineligible to apply. All DSRIP funds will be based on performance linked to achievement of project milestones.

Key Initiatives

Social Determinants of Health and Community Based Organizations

Social Determinants of Health (SDH) are defined as the conditions in which people are born, live, grow, work, and age. These conditions can affect a wide range of health risks and outcomes. The five key domains of social determinants of health (SDH) include: economic stability, education, social and community context, health and health care, and, neighborhood and built environment. Integrating health and human services to address SDH can have a significant impact on health outcomes. Under Value Based Payment (VBP), VBP Contractors aim to realize savings while achieving quality outcomes by addressing SDH conditions that drive health costs and poor health outcomes.

First 1000 Days on Medicaid Initiative

On July 20, 2017, former Medicaid Director Jason Helgerson announced a new focus for Medicaid Redesign in New York: The First 1,000 Days on Medicaid initiative. This initiative recognized that a child´s first three years are the most crucial years of their development. We also know that there is evidence that children on Medicaid have better health and life outcomes. We must take steps to ensure that New York´s Medicaid program is working with health, education and other system stakeholders to maximize outcomes and deliver results for the children we serve.

Home & Community-Based Services (HCBS) Final Rule

In 2014, the Centers for Medicare and Medicaid Services (CMS) published the HCBS Final Rule related to Medicaid–funded Home and Community–Based Services (HBCS). This rule implements a number of changes to home and community–based waivers, and imposes new requirements on what is considered an appropriate home and community–based setting for all the authorities in its scope.

Community First Choice Option (CFCO)

The Centers for Medicare and Medicaid Services (CMS) approved the State´s Medicaid Plan Amendment to add the Community First Choice Option (CFCO) set of services. CFCO, authorized in the Affordable Care Act, allows states to expand access and availability of long term services and supports.

2014 Medicaid Perinatal Care Quality Improvement Initiative

The Medicaid Perinatal Care Quality Improvement Initiative is a statewide practice based project that includes an on-going evaluation of the quality of perinatal care being delivered to Medicaid-eligible pregnant women within prenatal care practices, as well as health plans.

A 2011 New York State Department of Health (NYS DOH) study utilizing standard of care measures identified many strengths as well as several important clinical gaps in care and opportunities to advance prenatal care quality for Medicaid members. Study recommendations include on-going monitoring of compliance with ACOG-recommended best practices and, most notably, of key performance indicators related to those gaps.

Uniform Assessment System for New York

In March 2013, the Office of Health Insurance Programs, Division of Long Term Care began the implementation of the Uniform Assessment System for New York (UAS–NY). The overall goal of the UAS–NY is to utilize a comprehensive assessment system within eight Medicaid home and community–based long–term care services and programs. The transition to the UAS–NY is expected to be completed by March 2014.

Project Information and Updates
The availability of information to the appropriate providers will support care planning and service delivery for an individual.

The UAS–NY includes the following three assessment instruments:

- UAS–NY Community Assessment, a comprehensive assessment used for adults, age 18 and over, in home and community–based long–term care programs
- UAS–NY Pediatric Assessment for Ages 4 through 17
- UAS–NY Pediatric Assessment from Birth through Age 3

The UAS–NY contains reporting functionality for information on individuals assessed, as well as aggregate or agency–wide information, which will be immediately available to users during and upon completion of the assessment. The UAS–NY also includes an ad hoc reporting function that will enable users to create customized reports and to download information from the UAS–NY. This data can then be uploaded to an organization's local management system. The UAS–NY includes an integrated training environment to help users learn about the UAS–NY assessment instruments and the application. The UAS–NY Training Environment is accessed through the Health Commerce System (HCS) and includes a range of online, self–paced courses and a wide of resources designed as an ongoing resource to promote the effective use of the UAS–NY.

The UAS–NY will be used in the following programs and plans: Adult Day Health Care, Assisted Living, Care at Home I and II, Managed Long Term Care, Long Term Home Health Care, Personal Care, Consumer Directed Home Care, Nursing Home Transition and Diversion Waiver, and Traumatic Brain Injury Waiver.

NYS Money Follows the Person Demonstration (MFP)

In January 2007, the federal Centers of Medicare and Medicaid Services (CMS) approved New York´s application to participate in the Money Follows the Person Rebalancing Demonstration Program (MFP). The MFP Demonstration, authorized under the Deficit Reduction Act and extended through the Affordable Care Act, involves transitioning eligible individuals from long-

term institutions like nursing facilities and intermediate care facilities into qualified community-based settings. The initiative assists people who want to leave institutional care and receive services in their community of choice. The MFP Rebalancing Demonstration Grant helps states rebalance their Medicaid long-term care systems.

Who is eligible for MFP?

To be eligible for MFP participation the individual must meet the following criteria:

- Have resided in a qualified institution (hospital, nursing home, or ICF/IID) for not less than 90 consecutive days (minus Medicare covered rehabilitative days) immediately prior to transitioning to the community;
- Be Medicaid eligible at least one day prior to discharge/transition;
- Meet the eligibility/enrollment criteria associated with a constituent program;
- Have health needs that can be met through services available in the community;
- Voluntarily consent and participate;
- Transition into a qualified residence.

What is a qualified residence?

A qualified residence, as defined by the Deficit Reduction Act is:

- A home owned or leased by an individual or family member; or
- An apartment with an individual lease, with lockable access and egress, which includes living, sleeping, bathing, and cooking areas over which the individual or the individual´s family has domain and control; or
- A community–based residence in which no more than 4 unrelated individuals reside.

How has MFP helped?

An important role of MFP in New York State is making sure that individuals have the chance to express their opinions and feelings about the services they receive. MFP offers participants the opportunity to participate in a confidential survey that asks questions about their experiences in the nursing facility or other institutional setting, and in the community. The survey, called the Quality of Life survey, measures life satisfaction in a variety of areas such as living situation, choice and control, community inclusion, and overall life satisfaction. The survey is asked twice: once while the person still lives in the facility or institution and once about 11 months after he or she moves to the community. The survey is voluntary; participants may choose not to be asked these questions. The survey results provide helpful information to the Department of Health and to the public about MFP's effectiveness at helping participants to successfully live in the community.

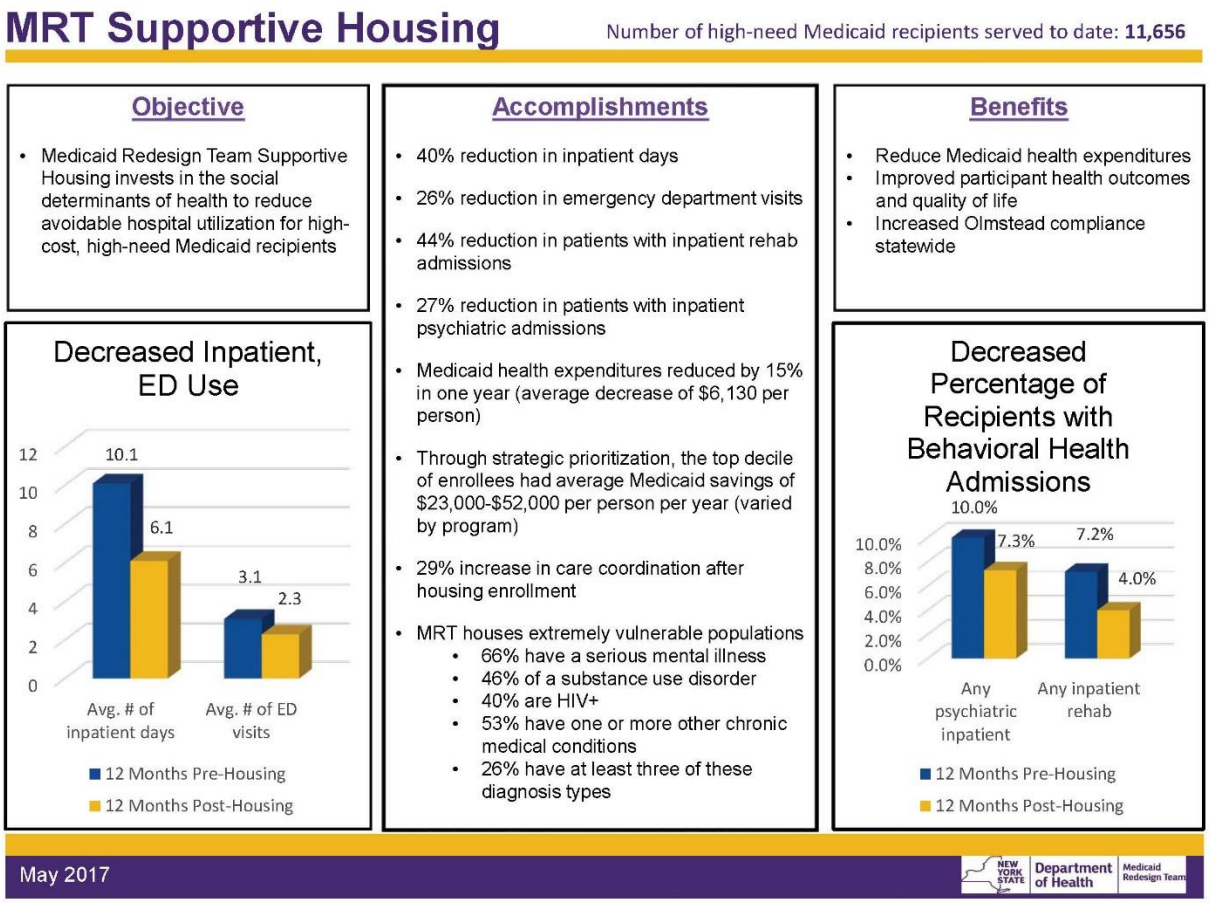
Medicaid Redesign Team Supportive Housing Initiative

The Medicaid Redesign Team (MRT) Supportive Housing Initiative invests into housing as a social determinant of health to improve the quality of care to the vulnerable Medicaid population. MRT provides funding for rental subsidies, support services and capital projects.

MRT Supportive Housing Evaluation

The Medicaid Redesign Team created numerous supportive housing programs to provide vulnerable high–cost Medicaid members with rental subsidies, new capital construction and pilot projects to test new models of care. Since 2012, over 12,000 high acuity Medicaid members have been served. Early findings demonstrate that investments in social determinants, such as housing, can have a profound impact on health care costs and utilization, including:

- 40% reduction in inpatient days
- 26% reduction in emergency department visits
- 15% reduction in overall Medicaid health expenditures



Care Management For All

The NYS Department of Health has established a goal of having virtually all Medicaid enrollees served in care management by 2019. This initiative, deemed Care Management for All, began in SFY 11/12 as a Medicaid Redesign Team (MRT) proposal. It will improve benefit coordination, quality of care, and patient outcomes over the full range of health care; including mental health, substance abuse, developmental disability, and physical health care services. It

will also redirect almost all Medicaid spending in the state from fee–for–service Medicaid (under which health services providers bill directly to the state) to "care management", under which a managed care organization is paid a capitated rate by the state and is then responsible for managing patient care and reimbursing service providers. The care management system currently in place includes comprehensive plans, HIV/AIDS special needs plans, partial capitation long term care plans, and Medicare/Medicaid supplemental plans. As Care Management for All comes to fruition, additional Medicaid managed care plans tailored to meet the needs of the transitioning population will be added, including mental health and substance abuse "Health and Recovery Plans" (HARPs), and "Fully Integrated Duals Advantage" (FIDA) plans for Medicare/Medicaid "dual eligibles".

As of April 1, 2012, nearly four million of the five million NYS residents enrolled in Medicaid were already in care management, with, however, a significant portion of the benefits for those persons remaining outside the care management benefit package. Over the next several years, the bulk of the excluded benefits and patient populations will move into care management.

As the *Care Management for All* implementation moves ahead:

- Enrollment in care management will rise to 95% of the Medicaid population.
- Fee–for–service spending will ultimately drop to only 4% of all Medicaid spending.
- Medicaid spending flowing through care management will exceed $45B.

Fully Integrated Duals Advantage (FIDA)

FIDA is a personal health care plan that´s centered on **you**. One plan that brings together the resources of Medicare and Medicaid. A plan that gives you all the care you need in one place. We know that health care decisions can be overwhelming for you and your family, especially when you have both Medicare and Medicaid coverage. We are always looking for ways to make this process easier so that you can simply focus on getting the care you need.

This is why the New York State Department of Health (NYSDOH) has partnered with the Centers for Medicare and Medicaid Services (CMS) to offer you a program that will provide you with the most complete care package that has ever been available in the State. This new program is called Fully Integrated Duals Advantage, or "FIDA" for short. Currently, there are 10 FIDA plans in the FIDA program.

In a FIDA plan, you will:

- Receive full Medicare and Medicaid coverage, long term care services, Part D and Medicaid drugs, and additional benefits from a single, integrated managed care plan. In other words, FIDA covers all the benefits that you may receive through your managed long term care (MLTC) plan, Original Medicare or your Medicare Advantage plan, and your Part D plan.
- Pay no new or additional deductibles, premiums, or copayments/coinsurance to the plan. (If you have Medicaid with a "spend–down" or "excess income," you will have to continue to pay your spend–down to the FIDA plan.)
- Be able to access specialists directly. No need for provider referrals.
- Stay in your current nursing home even if you change FIDA plans.

- Have a Care Manager who can schedule doctor´s appointments, arrange transportation and help you get your medicine. (In most cases, you will keep your current care manager.)
- Have a care team made up of members that you choose. Your care team can be as small (just yourself and your Care Manager) or as large as you decide.
- Have the option to add your Medicare and Medicaid doctors and specialists to your care team. All of whom will be able to share with each other their professional opinions about your health condition. That way, they can provide the most complete care for you and connect you to a wide variety of options for health care and supportive services.
- Have the option to add your caregivers or anyone you trust, like your friends and relatives, to your care team. They will be able to stay with you during the care team meetings and help you make the right decisions about your care.
- Use one FIDA Plan phone number for all questions regarding your benefits.
- Have the right to leave FIDA at any time and for any reason. If you decide to do so, you will continue to receive all of your Medicaid long term care benefits through the MLTC program and all of your Medicare benefits through Original Medicare or a Medicare Advantage plan, and a Part D plan.

Health and Recovery Plan (HARP)/ Behavioral Health

Health and Recovery Plans (HARPs) will manage care for adults with significant behavioral health needs. They will facilitate the integration of physical health, mental health, and substance use services for individuals requiring specialized approaches, expertise and protocols which are not consistently found within most medical plans. In addition to the State Plan Medicaid services offered by Mainstream MCOs, qualified HARPs will offer access to an enhanced benefit package comprised of Home and Community Based Services (HCBS) designed to provide the individual with a specialized scope of support services not currently covered under the State Plan.

Individuals currently enrolled in HIV Special Needs Plans (HIV SNPs) meeting the serious mental illness (SMI) and substance use disorder (SUD) targeting criteria and risk factors for HARP will also be eligible to receive HCBS while enrolled in their HIV SNP. Access to HCBS for HIV SNP enrollees will require an assessment consistent with the HARP program.

All individuals enrolled in HARPs and those in HIV SNPs meeting the SMI and SUD targeting criteria and risk factors for HARP will be offered Health Home care management services. Eligibility for HCBS is determined through an assessment, called the New York State Eligibility Assessment, conducted by Health Home care managers. If an individual is determined eligible for HCBS, the Health Home care manager will complete the full New York State Community Mental Health Assessment. Health Homes will develop person–centered plan of care that integrates physical and behavioral health services and includes HCBS for individuals who are eligible.

Delivery System Reform Incentive Payment (DSRIP) Program

On April 14, 2014 Governor Andrew M. Cuomo announced that New York has finalized terms and conditions with the federal government for a groundbreaking waiver that will allow the state to reinvest $8 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms.

The waiver amendment dollars will address critical issues throughout the state and allow for comprehensive reform through a Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program will promote community-level collaborations and focus on system reform, specifically a goal to achieve a 25 percent reduction in avoidable hospital use over five years. Safety net providers will be required to collaborate to implement innovative projects focusing on system transformation, clinical improvement and population health improvement. Single providers will be ineligible to apply. All DSRIP funds will be based on performance linked to achievement of project milestones.

The $8 billion reinvestment will be allocated in the following ways:

- $500 Million for the Interim Access Assurance Fund – temporary, time limited funding to ensure current trusted and viable Medicaid safety net providers can fully participate in the DSRIP transformation without disruption
- $6.42 Billion for Delivery System Reform Incentive Payments(DSRIP) – including DSRIP Planning Grants, DSRIP Provider Incentive Payments, and DSRIP Administrative costs
- $1.08 Billion for other Medicaid Redesign purposes – this funding will support Health Home development, and investments in long term care, workforce and enhanced behavioral health services

In addition, the special terms and conditions also commit the state to comprehensive payment reform and continuing New York's effort to effectively manage its Medicaid program within the confines of the Medicaid Global Spending Cap.

Total Care for the General Population Value Based Payment Arrangement

The total Care for the General Population Value Based Payment Arrangement is designed to incentivize primary care professionals, in cooperation with behavioral health providers, community–based providers, medical specialists, and other health care professionals, to improve the quality of care delivered to the New York State (NYS) Medicaid population. With a focus on outcomes and costs, the Arrangement contracts for all care provided to the attributed Medicaid population, thus encouraging VBP Contractors to focus on the delivery of high–value, evidence–based care. A VBP Contractor is an entity – a provider or group of providers – engaged in a VBP contract. The TCGP Arrangement includes all services covered by mainstream managed care for the attributed population.

The TCGP Arrangement provides the impetus for significant investment in population management, including preventive care, care management for chronic conditions, and care

coordination. Savings in a TCGP contract are primarily achieved through improved outcomes, resulting from a reduction of variation in unnecessary care (including ancillary and in–patient care) and improved adherence to guideline–driven, evidence–based care. This reduction in variation decreases downstream costs through initiatives that reduce the risk of acute medical events and the probability of inpatient hospitalizations.

Defining the TCGP Population and Associated Costs

The TCGP Arrangement addresses the total care and the associated costs of that care for the members attributed under the Arrangement, regardless of where, how, or for what reason the care was delivered. VBP Contractors assume responsibility for the quality and costs for all care for attributed members including primary care, specialty care, psychiatric rehabilitation services, emergency department visits, hospital admissions, and medication (with a cap for specialty, high–cost drugs).

Constructing the TCGP Arrangement: Time Window and Services

Achieving improved clinical and financial outcomes under the TCGP arrangement requires that VBP Contractors successfully manage patients at the population level, build a network of provider partners consistent with the care management needs of the attributed population, and work closely with teams across the continuum to efficiently coordinate care, identify improvement opportunities, and track planned improvements. This provider network would include primary care providers, behavioral health providers, specialists, and others necessary to provide the comprehensive level of care needed for the population.

The TCGP Arrangement encompasses all services covered by mainstream Medicaid Managed Care provided to the attributed member population during the contract year. This includes preventive care, sick care, the care for all acute and chronic conditions, and emergency medical care, as well as procedures or surgeries with a date of service or discharge date within the contract year.

VBP Quality Measure Set for the TCGP Arrangement

The 2018 TCGP/IPC Quality Measure Set was developed drawing on the work of a number of stakeholder groups convened by the Department of Health (DOH) to solicit input from expert clinicians around the state. The physical health measures were drawn from the measure sets developed by the Diabetes, Chronic Heart Disease, and Pulmonary Clinical Advisory Groups, or CAGs, and from the measures recommended for Advanced Primary Care (APC) by the Integrated Care Workgroup. Likewise, the behavioral health measures were drawn from the measure sets developed by the Behavioral Health CAG.

Because the TCGP VBP Arrangement is a total cost of care arrangement, the State is recommending a full complement of physical and behavioral health measures to help ensure attributed members receive high quality physical, as well as behavioral, health care.

Vital Access Provider (VAP) Program

Purpose
To provide operating assistance to financially distressed hospitals, nursing homes, DTCs, and CHHAs for the purpose of redesigning their healthcare delivery systems in order to assist in financial stability.

Program Overview:
Specifically, the Vital Access Provider Program (VAP) was implemented to help fund operational costs for turnaround initiatives to help financially distressed New York State healthcare entities:

- Improve facility financial viability
- Meet community service needs
- Improve the quality of care, and
- Increase health equity for populations at risk

The program is funded through even shares of state and federal dollars. The Center for Medicare and Medicaid Services (CMS) must approve the State Plan Amendment (SPA) before funds can be distributed. Eligible applicants include Article 28 Hospitals, Nursing Homes, Diagnostic and Treatment Centers (DTCs), and Certified Home Health Agencies (CHHAs).
Providers receiving large VAP Awards and facilities deemed to need assistance to operate in a financially efficient manner will have a strategic planner (SP). The assigned SP can help guide them through the VAP funding requirements and ensure that funds are used efficiently, effectively and for the intended purposes.

Expected Outcomes Include:

- Financially stabilize facilities
- Improve community access to the appropriate level of services
- Improve quality of care
- Reduce Medicaid program costs

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