NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES
40 NORTH PEARL STREET, ALBANY, NEW YORK 12243-0001

MARY JO BANE
Commissioner

(518) 474-9475

LOCAL COMMISSIONERS MEMORANDUM

DSS-4037EL (Rev. 9/89)

Transmittal No: 92 LCM-73

Date: May 1, 1992

Division: Medical Assistance

TO: **Local District Commissioners**

SUBJECT: Chapter 41 Of The Laws Of 1992: Changes To The Medical Assistance Program

ATTACHMENTS: Psychotropic Drugs Which Are Exempt From Co-Payment (available on-line)

Dear Home Relief Recipient letter #920944 (including Medical Care Coordinator Program MCCP Provider Selection Form (not available on line)

Dear Medicaid Recipient letter #920943 (not available on line)

Applicable sections of Chapter 41 of the Laws of 1992 (not available on-line)

This Local Commissioners Memorandum (LCM) is to inform you of changes to the Medical Assistance (MA) Program resulting from the recently enacted State budget legislation (Chapter 41 of the Laws of 1992). A brief summary of the most significant changes and their associated implementation dates follows. Letters to recipients (attached) explaining the changes to the MA Program specified in items I. through VII. are in the process of being mailed out. Letters to providers regarding items I. through VII. will be mailed in the near future.

NOTE: Given the reductions in coverage and benefits available to federally nonparticipating (FNP) MA recipients, districts are encouraged to enhance current procedures for the identification of individuals appropriate for disability reviews/determinations. Additionally, recipients are being advised to contact their local district if they believe they are disabled so that such determinations can be made.

I. CHANGE IN DEFINITION OF MEDICAL ASSISTANCE

Effective April 2, 1992 the official definition of "Medical Assistance" has been amended. The new definition will have impact on future determinations of exactly what is or what is not a covered service, supply or care under the MA Program. The amended Social Services Law (SSL) will provide the Department with the necessary authority to pay for only medically necessary medical, dental and remedial services that are provided for in law or regulation.

II. CHANGES IN COVERAGE OF PODIATRY SERVICES

Effective July 1, 1992 fee for service podiatry payments will only be made for services provided to the following individuals:

- Medicaid eligibles who are under twenty-one years of age and only by written referral from a physician, physician's assistant, nurse practitioner or nurse midwife.

- Those who are identified as Qualified Medicare Beneficiaries (QMBs). Until further notice podiatrists will be reimbursed for care provided to all Medicare beneficiaries.

For all other MA eligibles: As of July 1, 1992 podiatry services provided by independent practitioners will no longer be covered. Podiatry care provided by clinics and nursing homes is covered if podiatry service is included in the MA reimbursement rate.

III. CHANGES IN BENEFITS AVAILABLE TO FEDERALLY NONPARTICIPATING (FNP) RECIPIENTS AGED TWENTY-ONE THROUGH SIXTY-FOUR YEARS WHO HAVE NOT BEEN CERTIFIED AS BLIND OR DISABLED FOR MEDICAID PURPOSES

A. Eligibility For Full Benefits

Effective July 1, 1992 recipients who are twenty-one years of age through sixty-four years of age and who have not been certified as blind or disabled for Medicaid purposes and are eligible for or in receipt of Home Relief (FNP recipients) may receive the full range of MA covered services only if they are enrolled in one of the following programs:

1. A health maintenance organization (HMO) or other entity which provides comprehensive health services;
2. A managed care program or other primary provider program, as specified by the Department;
3. The Recipient Restriction Program; or

4. A voluntary Medical Care Coordinator (MCC) Program. A brief description of the MCC Program follows in section VII of this correspondence; a more descriptive Administrative Directive (ADM) will be sent in the near future.

Note : If there is no provider affiliated with any of such programs defined above who is sufficiently accessible to a recipient as to reasonably provide services to the recipient then the recipient will be eligible for the full range of benefits.

B. Eligibility For Reduced Benefits Only

Effective July 1, 1992 the following services are ELIMINATED from coverage for FNP recipients who do not qualify for the full range of benefits:

- o Transportation
- o Home Health (except Tuberculosis Directly Observed Therapy)
- o Personal Care (except Tuberculosis Directly Observed Therapy)
- o Private Duty Nursing
- o Speech, Occupational, and Physical Therapies provided by independent practitioners
- o Sickroom Supplies (except family planning items)
- o Orthotic Devices, including Hearing Aids and Prescription Footwear
- o Clinical Psychology provided by independent practitioners
- o Audiology provided by independent practitioners
- o Nursing Facilities

Note: Payments to nursing facilities for recipients receiving nursing facility services on July 1, 1992 will continue to be made. Eligibility for Home Relief recipients in these settings should be reviewed to determine whether they should be in a federally participating aid category.

IV. THIRTY-TWO DAY HOSPITAL INPATIENT LIMITATION FOR FNP RECIPIENTS AGED TWENTY-ONE THROUGH SIXTY-FOUR YEARS WHO HAVE NOT BEEN CERTIFIED AS BLIND OR DISABLED FOR MEDICAID PURPOSES

Effective May 1, 1992 payment for hospital inpatient services (per diem days, alternative level of care days and for Diagnosis Related Groups claims, the actual number of days of the hospital stay) for FNP recipients, except those who are covered under a full capitation program, will be limited to a maximum of thirty-two days of care per year. For calculation purposes the year referred to begins on May 1 and ends on April 30. Recipients who become MA eligible after May 1st are eligible for 32 days of care for the time period beginning with the first day of MA eligibility and ending on April 30 (e.g. A recipient who becomes MA eligible on July 1, 1992 will be eligible for 32 days of care during the time period beginning July 1, 1992 and ending April 30, 1993).

The Department is developing a system, which hospitals will be able to access through the Electronic Medicaid Eligibility Verification System (EMEVS), to identify the approximate number of service days available for a recipient and to obtain an authorization to provide service. As this system will not be in place until after May 1, 1992 providers are being notified that, when the system is in place, retroactive adjustments in payments will be made to recoup MA payment for HR recipients who have exceeded the 32 day stay limitation.

Hospitals are prohibited from discharging an inpatient solely as a result of his or her having received the maximum number of service days for which MA payment is available.

V. CHANGES TO THE UTILIZATION THRESHOLD PROGRAM

A. Changes Affecting FNP Recipients

1. Effective July 1, 1992 the following thresholds will apply:

   Physician/clinic - ten (10) visits per benefit year
   Pharmacy - twenty-eight (28) items per benefit year

2. Effective September 1, 1992 psychiatric services provided by either psychiatrists, clinical psychologists or outpatient clinics will be subject to a threshold of forty (40) visits per benefit year.

B. Changes Affecting All Other MA Recipients In Federally Participating Aid Categories Regardless Of Age

Effective September 1, 1992 pharmacy services will be subject to a threshold of forty (40) items per benefit year.

C. Changes Affecting Recipients Covered By The Restricted Recipient Program

Effective September 1, 1992 restricted recipients will no longer be exempt from utilization thresholds.

VI. CO-PAYMENT FOR SELECTED SERVICES

Effective June 1, 1992 co-payments will be instituted for most MA recipients for selected services listed in section VI.C. of this correspondence.

In anticipation of the need to respond to recipient concerns the Department has established a toll free hotline for recipients to report providers who may be inappropriately denying services due to co-payment issues. The hotline number is **1-800-541-2831.** This hotline should only be used to report co-payment problems; recipients will be instructed to contact their local social services office if they have any questions about the other program changes detailed in this correspondence.

A. Exempt recipients include the following:

- o Recipients under the age of twenty-one
- o Pregnant women
- o Recipients institutionalized in a medical facility who are required to spend all of their income, except for a personal needs allowance, on medical care. This includes all recipients in a nursing facility and Intermediate Care Facility for the Developmentally Disabled (ICF/DD).
- o Recipients enrolled in HMOs and Managed Care programs

B. Exempt services include the following:

- o Emergency services
- o Family planning services
- o Tuberculosis Directly Observed Therapy

C. Co-payments will apply to the following services:

- o Inpatient hospital services provided by Article 28 facilities, hospitals with dual certification, and out of state hospitals
- o Outpatient hospital and Clinic (except Methadone Maintenance Treatment Programs, mental health clinic services, mental retardation clinic services, alcohol and substance abuse clinic services , Tuberculosis Directly Observed Therapy)
- o Nonemergency/nonurgent visits to emergency rooms (ER)
- o Drugs (Exceptions: 1. psychotropic drugs, to be defined by the Department, 2. family planning drugs)
- o Enteral and Parenteral formulae/supplies
- o Medical/surgical supplies (except family planning items)
- o Home health services; including long term home health services and home health nursing
- o Laboratory services (except when provided by physicians who bill directly and are not licensed as a provider of laboratory services)
- o X-ray services (except when service provided by physicians)

D. Co-payment amounts are as follows:

Service	Amount ($)
Inpatient Hospital	25.00 per stay upon discharge
Outpatient Hospital and Clinic	3.00 per visit
Nonemergency/Nonurgent ER Visits	3.00 per visit
Prescription Drugs, Generic	0.50 per prescription
Brand	2.00 per prescription
Psychotropic	NO CO-PAYMENT
Nonprescription Drugs	0.50 per order
Enteral/Parenteral Formulae/Supplies	1.00 per order/prescription
Medical/Surgical Supplies	1.00 per order
Laboratory	0.50 per procedure code
X-ray	1.00 per procedure code
Home Health (Including LTHHC and Home Health Nursing)	Depending on rate code either 0.25 per hour or 3.00 per visit up to a maximum of 3.00 per claim

The following rate codes REQUIRE a $3.00 per visit co-payment:

- 2787 - Nursing Assessment
- 2619 - HHA, AIDS, Nursing Services (Episodic, RN)
- 2677 - HHA, AIDS, Physical Therapy, 1 Client, 1 Visit
- 2678 - HHA, AIDS, Occupational Therapy, 1 Client, 1 Visit
- 2679 - HHA, AIDS, Speech Therapy, 1 Client, 1 Visit
- 2518 - RHCF (HB) Home Hlth Aide (Hr or Visit) Seco
- 2620 - HHAS (FS) Nursing
- 2621 - HHAS (FS) Long Term Nursing
- 2640 - HHAS (FS) Occupational Therapy
- 2641 - HHAS (FS) Long Term Occupational Therapy
- 2650 - HHAS (FS) Physical Therapy
- 2651 - HHAS (FS) Long Term Physical Therapy
- 2652 - HHAS (FS) Audiology (LTHHCP)
- 2660 - HHAS (FS) Spch Therapy (Obs-Replaced by 2662)
- 2661 - HHAS (FS) Long Term Speech Therapy
- 2662 - HHAS (FS) Speech Pathology
- 2680 - HHAS (FS) Spch Eval (Obs-Replaced by 2662)
- 2686 - RHCF (HB) D.HHAS Nursing - AIDS
- 2687 - HHAS (FS) HHA, AIDS - Nursing
- 2688 - HHAS (FS) Community LTHHC PRI+Screen
- 2811 - RHCF (HB) D.HHAS Long Term Nursing (Hospit)
- 2812 - RHCF (HB) D.HHAS Long Term Occupational Therapy
- 2813 - RHCF (HB) D.HHAS Long Term Physical Therapy
- 2814 - RHCF (HB) D.HHAS Long Term Speech Therapy
- 2842 - RHCF (HB) D.HHAS Nursing
- 2844 - RHCF (HB) D.HHAS Occupational Therapy
- 2845 - RHCF (HB) D.HHAS Physical Therapy
- 2846 - RHCF (HB) D.HHAS Speech Therapy (Obs Replaced)
- 2847 - RHCF (HB) D.HHAS Speech Pathology
- 2848 - RHCF (HB) D.HHAS Spch Eval (Obs-Replaced)
- 2849 - RHCF (HB) D.HHAS Physical Therapy Evaluation
- 3830 - RHCF (FS); C.HRF Nursing LTHHC, PRI Screening

- 3851 - RHCF (FS); C.HRF Long Term Nursing (RHCF)
- 3852 - RHCF (FS); C.HRF Long Term Occupational Therapy
- 3853 - RHCF (FS); C.HRF Long Term Physical Therapy
- 3854 - RHCF (FS); C.HRF Long Term Speech Therapy
- 9980 - MISC Hosp. LTHHC, PRI & Screen

The following rate codes REQUIRE a $.25 per hour (unit of service) co-payment:

- 2617 - HHA, AIDS, Home Nursing, Private Duty, LPN, Ho
- 2618 - HHA, AIDS, Home Nursing, Private Duty, RN, H
- 2668 - HHA, AIDS, Home Health Aide, Hourly
- 2515 - HHAS (FS) Home Health Aide (Hrly) Secondary
- 2516 - RHCF (HB) Home Health Aide (Hrly) Secondary
- 2517 - HHAS (FS) Home Health Aide Secondary Cod
- 2519 - RHCF (FS) Home Health Aide Secondary Cod
- 2610 - HHAS (FS) Home Health Aide
- 2611 - Long Term Home Health Aide
- 2631 - HHAS (FS) Long Term Homemaker
- 2669 - HHAS (FS) Home Health Aide (Per Hour)
- 2671 - HHAS (FS) Long Term Housekeeper
- 2695 - HHAS (FS) Respite Long Term Home Health AI
- 2696 - HHAS (FS) Respite Long Term Home Health Hom
- 2697 - HHAS (FS) Respite Long Term Home Health Hou
- 2810 - RHCF (HB); D.HHAS Long Term Home Health Ai
- 2815 - RHCF (HB); D.HHAS Long Term Homemaker
- 2816 - RHCF (HB); D.HHAS Long Term Housekeeper (H
- 2825 - RHCF (HB); D.HHAS Respite Long Term Home Health
- 2826 - RHCF (HB); D.HHAS Respite Long Term Home Care
- 2841 - RHCF (HB); D.HHAS Home Health Aide (Per Visit)
- 2878 - RHCF (HB); D.HHAS Home Health Aide (Per Hour)
- 3850 - RHCF (FS); C.HRF Long Term Home Health Aid
- 3855 - RHCFS (FS); C.HRF Long Term Homemaker (RHCF)
- 3856 - RHCFS (FS); C.HRF Long Term Housekeeper (RHCF)
- 3865 - RHCFS (FS); C.HRF Respite Long Term Home Health
- 3866 - RHCFS (FS); C.HRF Respite Long Term Home Care
- 3867 - RHCFS (FS); C.HRF Respite Long Term Care Housing
- 3876 - RHCFS(FS); C.HRF Home Health Aide

VII. MEDICAL CARE COORDINATOR PROGRAM (MCC)

Effective July 1, 1992 Home Relief recipients will have the option to choose enrollment in the MCC Program. Home Relief recipients who choose the MCC Program will select a primary medical provider (physician or clinic) and a primary pharmacy. A form to be used by the recipient to identify his/her choice of primary medical provider and primary pharmacy will be sent to recipients in the notification mailing. This draft version of the form can be used until the final version is sent (see attached). These providers will function as the recipient's medical care coordinators. Functionally, the MCC Program will operate in a manner identical to the Recipient Restriction Program (RRP). The most significant difference in the RRP and the MCC

Program is that restricted recipients have a history of abusive utilization of Medicaid services while recipients participating in the MCC Program do not. HR recipients who volunteer for the MCC Program are eligible for the full range of Medicaid covered services.

All of the policy requirements governing the RRP remain in effect for the MCC Program. Under both programs, the recipient's primary physician or clinic must order all ancillary services such as prescription drugs, laboratory tests, durable medical equipment, and non-emergency transportation, and make all necessary referrals. Providers to whom a recipient is referred by his/her primary physician or clinic may also order these ancillary services, with the exception of nonemergency transportation which must always be ordered by the recipient's primary provider.

Recipients who have been assigned to a primary physician or clinic and primary pharmacy under the MCC Program are required to receive all care within the provider's scope of practice from the selected caregiver except under the following circumstances:

- o in cases of documented emergencies;
- o in cases where the primary physician or clinic has referred the recipient to another provider; or
- o in cases where the service provided is either methadone maintenance, or a service provided in an inpatient setting.

To encourage office based physician participation in the MCC Program, a $10.00 monthly management fee to be paid to primary physicians has been established. This monthly fee is payable, provided the recipient remains eligible, even though the recipient may not have visited the physician during the month.

New values have been added to the restriction subsystem of WMS to accommodate the MCC Program. The codes will be available to the local agencies sometime before July 1, 1992; more descriptive information will be included in an ADM in the near future. These codes, which are effective on July 1, 1992, are as follows:

53 Client lives in underserved area

55 Primary pharmacy

56 Primary physician

58 Primary clinic

The current procedures in effect under the RRP for entering restriction data into WMS apply to the MCC Program. These include provider type, provider number, and begin date.

The Department will assist local districts to identify providers participating in the MCC Program. However, if a client lives in an area that is underserved by the Medicaid provider community, as determined by the local district in conjunction with the Department, and no primary providers are available to serve as his/her medical care coordinator, that recipient is eligible to receive the full range of Medicaid covered services without participating in the MCC Program. When this occurs the local district should enter code 53 for that recipient in the WMS restriction subsystem.

An ADM which will provide more detailed information on this new program will be sent to local social services agencies. This ADM will include instructions on how recipients choose their primary providers and the form that will be used in the selection process.

VIII. CHANGE TO ESTATES, POWERS AND TRUSTS LAW

Section 86 of Chapter 41 adds a new paragraph (c) to section 7-3.1 of the Estates, Powers and Trusts Law (EPTL). Section 7-3.1(c) provides that any provision in a trust (other than a testamentary trust) which directly or indirectly suspends, terminates or diverts the beneficial interest of the creator or the creator's spouse when the creator or the creator's spouse applies for MA or requires "medical, hospital or nursing care or long term custodial, nursing or medical care" is void, without regard to the irrevocability of the trust or the purpose for which the trust was created.

As defined in section 369.3 of the SSL, the beneficial interest of the creator or the creator's spouse includes the income and principal of the trust to which the creator or the creator's spouse would have been entitled under the terms of the trust.

Therefore, a provision in a trust established on or after April 2, 1992 which suspends, terminates or diverts the beneficial interest upon application for MA is void. The total beneficial interest to which the creator or the creator's spouse would have been entitled with the full exercise of discretion by the trustee is considered available despite any language in the trust document which limits or excludes the availability of such interest for medical care.

IX. CHANGE TO SOCIAL SERVICES LAW REGARDING TRUSTS

Section 85 of Chapter 41 adds a new subdivision 3 to section 369 of the SSL to authorize the Department and any social services district to recover through Surrogate's Court the amount of MA paid on behalf of a creator or the creator's spouse from their beneficial interest in any trust (other than a testamentary trust).

SSL 369.3 clarifies the authority of a social services district to pursue recovery from the trustee(s), creator, or creator's spouse when MA is authorized in cases where, for example:

1. no individual is empowered to act on behalf of an applicant/recipient (A/R) who is unable to act on his or her own behalf;

2. a nonapplying legally responsible relative living in the community refuses to make his or her income and resources available to the A/R; or

3. where the spousal impoverishment undue hardship provision is met.

X. LIENS AND RECOVERIES

Section 85 of Chapter 41 also amends subdivisions 1 and 2 of section 369 of the SSL relating to liens, recoveries and adjustments for Medical Assistance (MA) correctly paid. In addition to the ability to recover for MA correctly paid from the estate of an individual who was 65 years of age or older when he or she received MA, SSL 369.1 and 369.2 now allow the placement of a lien on the property of an institutionalized individual who is not reasonably expected to be discharged and return home. (Any such lien dissolves if the individual does return home.) However, a lien cannot be imposed on the individual's home while any of the following relatives of the individual lawfully reside in the home:

1. spouse;

2. child under twenty-one years of age;

3. blind or permanently and totally disabled child of any age; or

4. sibling who has resided in the home for at least one year immediately preceding the date of the individual's admission to a medical institution and who has an equity interest in the home.

Further, recovery from a lien on an individual's home must not be made while any of the following persons continue to reside in the home:

1. a sibling of the individual who resided in the home for at least one year preceding the date of the individual's admission to a medical institution; or

2. a son or daughter of the individual who resided in the home for at least two years immediately preceding the date of the individual's admission to a medical institution, and who provided care which permitted the individual to reside at home rather than in a medical institution.

The son, daughter or sibling must have resided in the home on a continuous basis since the date of the individual's admission to a medical institution.

XI. UNCLAIMED RESOURCES OF DECEASED RECIPIENTS

As detailed in 88 INF-12 "Disposition of the Estate, Including the Personal Incidental Allowance Account, of a Deceased MA Only Recipient", the most common settlement of the estate of a deceased MA recipient is made by appointing a voluntary administrator under section 1303 of the Surrogate's Court Procedure Act (SCPA). This is an abbreviated estate settlement when the gross estate is less than $10,000 and does not include real property. If no relative of the deceased is willing or able to act as the voluntary administrator, upon notification, the chief fiscal officer or public administrator of the locality must seek the appointment of a voluntary administrator. The voluntary administrator is the only duly appointed fiduciary with the legal right to receive or distribute estate property. Possessors of estate property (e.g., nursing homes, medical institutions or facilities, banks) are legally liable for wrongfully withholding or disposing of estate property to other than the duly appointed fiduciary.

Section 87 of Chapter 41 adds a new subdivision 8 to section 1310 to the SCPA allowing the possessor of monies belonging to the estate of a deceased recipient to pay to the Department or a social services district the amount of MA furnished to or on behalf of the deceased creditor, without a formal estate proceeding or the appointment of a fiduciary.

SCPA 1310.8 applies when at least six months have passed since the death of the recipient. The social services district must provide an affidavit showing:

1. the date of the decedent's death;

2. that no executor or administrator has been appointed to administer the estate;

3. the decedent was not survived by a spouse or minor child;

4. that the social services district is entitled to be paid; and

5. that the deposit does not exceed $5,000.

Sections 85 - 87 of Chapter 41 of the Laws of 1992 are attached for your reference.

XII. TECHNICAL CORRECTIONS AND AMENDMENT TO SSL 366.5(c)(4)

Attached also are sections 64, 65, and 90 of Chapter 41 of the Laws of 1992. Section 64 is a technical correction to SSL 366.2(a) to support the current procedures for determining the amount of an institutionalized individual's income available for his or her cost of care, in accordance with 18 NYCRR 360-4.9. Section 65 is a technical correction to SSL 366.2(a)(4), which clarifies that the MA resource standard is one-half of the annual MA income standard. These technical corrections will not require any action.

Section 90 amends SSL 366.5(c)(4) by adding the word "total" before "uncompensated value" in clause (ii) to conform the SSL with section 1917(c) of the Social Security Act. An ADM will be forthcoming detailing the implementation of changes to the treatment of multiple transfers of resources.

Chapter 41 further provides that, notwithstanding the absence of implementing regulations, sections 85 and 87 (items IX.,X. and XI. of this LCM) are effective upon enactment, and section 86 (item VII.) is effective for trusts created on or after the date of enactment. Therefore, social services districts should track all potentially affected cases pending the issuance of the ADM.

XIII. EFFICIENCIES IN THE FISCAL ASSESSMENT AND MANAGEMENT OF HOME CARE SERVICES.

This provision is found in Section 70 for home health services and Section 73 for personal care services.

(A) Hospice

Hospice is removed from the list of efficiencies required by Chapter 165 of the Laws of 1991. Social services districts will be required to have written agreements with any hospice(s) in the district or service area. The agreement must specify procedures for notifying recipients who are believed to be eligible, unless hospice is medically contraindicated by a recipient's physician, of the availability of hospice services. Also the agreement must specify the procedure for referring recipients to such hospice(s), if a recipient so chooses. This will assure that there is communication between social services districts and hospices and that the hospice benefit is used when appropriate to meet the client's needs.

A model agreement which can be used by social services districts will be developed and included in a forthcoming directive. In planning for the implementation of this provision, social services districts should identify all hospices in the district. If information is needed about the availability of hospices, contact Al Roberts at 1-800-342-3715, extension 3-5539, or directly at (518) 473-5539.

(B) Addition of Patient Managed Home Care as an Efficiency

Patient managed home care exists when the patient or client assumes responsibility for some aspect of the arrangement for or the management of the home care service(s) provided. Several social services districts have developed this service delivery model in accordance with Chapter 386 of the Laws of 1990 and have found that the cost of a unit of service is less than in the traditional service delivery model because the client is assuming responsibility for specific portions of the management of the service.

The current demonstration project, outlined in 91 LCM-35, is not filled to capacity. Any social services district interested in developing patient managed home care should contact Fred Waite at 1-800-342-3715, extension 3-5498 or directly at (518) 473-5498.

C) Mandate the Use of the Efficiencies

The previous statute (Chapter 165 of the Laws of 1991) required that the efficiencies must be considered in the development of a care plan. The change in Chapter 41 of the Laws of 1992 requires that the client must use such efficiencies for maximum reduction in the need for home care services. This will assure that clients whose needs can be met by the use of personal emergency response services, shared aide, or another home care service must accept the most efficient service delivery model or service.

Social services districts which have not completed the development of plans for personal emergency response systems, required in 91 ADM-42, and for shared aide, required in 92 ADM-4, are reminded that those plans should be submitted for approval in order that these efficiencies are available in the district.

XIV. EXCEPTION CRITERIA IN THE FISCAL MANAGEMENT PROCESS FOR HOME CARE SERVICES

This provision is found in Section 71 for home health services and Section 74 for personal care services.

Chapter 165 of the Laws of 1991 included six exception criteria which are used to determine whether home care services are appropriate for a client for whom the cost of care exceeds 90 percent of the average monthly cost of residential health care facility (RHCF) services in the district. The provisions of Chapter 41 of the Laws of 1992 changes these exception criteria as follows:

(1) Previously, the fourth criteria read as follows:

> "Home health or personal care services are most appropriate for the recipient's functional needs, living arrangements, and working arrangements; can be provided cost effectively; or based on the recipient's medical history, the recipient's ability to perform the activities of daily living would diminish if he or she were institutionalized"

The revised criteria is as follows:

> "Home health or personal care services must be appropriate for the recipient's functional needs and institutionalization is contraindicated based on a review of the recipient's medical case history which must include a certified statement from the recipient's physican describing the potential impact of institutionalization. Further, the physician's certified statement on a form required by this Department and the Department of Health must be reviewed by a residential health care facility to determine if institutionalization would result in a diminishing of the recipient's ability to perform the activities of daily living."

Included in the upcoming directive implementing this provision will be a form which will be used to obtain the necessary certifications from the recipient's physician and the RHCF.

(2) The fifth exception criteria included that a placement at the level of institutional care for which the recipient is appropriate is not available. Since this exception criteria was not pertinent to determining whether a recipient is eligible for home cares services, the exception has been removed. The requirement that home care services can be continued until the appropriate level of RHCF is available is considered in a latter portion of the process.

XV. INSTRUMENTS FOR HOME CARE ASSESSMENT

This provision, found in Section 78 of Chapter 41, amends the Social Services Law by adding a new section 367-o, which requires that a new home care assessment instrument must be developed by this Department and the Department of Health. The purpose of this form is as follows:

(1) Assess the recipient's characteristics and service needs and determine whether home care services are appropriate and can be safely provided to the recipient;

(2) Refer the recipient to the home care services which will most appropriately and cost-effectively meet the recipient's needs or to other appropriate long-term care services; and

(3) Consider factors including but not limited to the following:

a. recipient's ability to perform activities of daily living;

b. recipient's health and rehabilitation needs; and

c. recipient's mental and physical ability to direct care and summon assistance and the availability, willingness and ability of others to provide care.

(4) Specify the maximum number of hours per month that will be paid by the Medical Assistance program, providing that the recipient's health and safety is not jeopardized.

(5) Serve as the basis for the recipient's plan of care; and

(6) Consider the relationship between or among all the services provided by the home care providers to which the recipient is referred, all other home care services available in the area, the availability of informal supports to provide care, the sources of informal support suggested by the recipient or the recipient representative and potential Medicare coverage of the recipient's care needs.

All recipients who are expected to receive care for more than 60 days and are receiving more than 156 hours per month will be reduced to 156 hours per month on July 1 unless the recipient is reassessed using the new instrument. All initial cases and cases being reassessed after July 1 must be assessed using the new instrument.

Currently, the Department and the Department of Health are involved in the field test of an instrument which, with modification, will be used to meet this requirement. It is expected that the instrument will be modified and finalized by mid-May. The Department is sending each district a list of those recipients who are receiving more than 156 hours per month according to the prior approval system.

Since the period for implementing the requirement for the new assessment instrument is short, social services districts are urged to plan ahead for the implementation. Several activities which might be done are as follows:

(1) Review files to identify all recipients who receive more than 156 hours per month. Also review the list which will be sent to the social services district so that any errors can be reconciled.

(2) Determine whether the health and safety of recipients who are receiving more than 156 hours per month will be jeopardized by a reduction to 156 hours.

XVI. OTHER LONG TERM CARE ITEMS

The statute also includes several other provisions as follows:

(1) Administrative Caps for Personal Care Services: There will be a cap on allowable reimbursement for administrative expenses that may be included within the Medicaid rates set for personal care services, including personal care services under the long term home health care program.

For rate periods beginning on or after January 1, 1992 , the reimbursement for administrative expenses cannot exceed twenty-eight (28) per cent of the total personal care rate for current service providers. This limitation does not apply to new providers in the first year of operation. The new law further provides that the ratio of administrative and general expenses divided by the total rate of payment, excluding any capital cost reimbursement, will be reduced according to the following scale:

ADMINISTRATIVE/GENERAL PERCENTAGE	PERCENTAGE POINT REDUCTION
26 - 31%	4 percentage points
22 - 26%	3 percentage points
20 - 22%	2 percentage points but not to be lower than 20%

The mandated administrative cap will become part of the 1992 rate setting process for all personal care service rates promulgated by the Department of Social Services for local department of social service personal care contracts and by the Department of Health for personal care rates associated with the long term home health care program.

(2) Physician Home Visit: Chapter 41 of the Laws of 1992 authorizes a physician fee increase for home visits by a physician or nurse practitioner when transportation costs a patient would otherwise require are avoided. More information about this provision will be available at a later date.

(3) Social Services District Delegation: The delegation of activities related to home care services, which currently are the responsibility of local districts, to providers or other entities have been authorized by statute. This provision will be discussed in greater detail in a separate Local Commissioners Memorandum.

(4) Adult Day Health Care: The recently enacted budget also reduced the allowable ceiling for rates paid to nursing facilities (NFs) for day care services provided to non-occupants from 75 percent of the facility's average in-patient rate to 65 percent. These new rates are currently being computed by the Department of Health, which plans to make them available during the first week of May, with an effective date of July 1, 1992. A letter explaining the rate reductions will be sent to all relevant providers by DoH.

Each of the major provisions of Chapter 41 of the Laws of 1992 affecting the delivery of home care services is effective on July 1, 1992.

The Division is in the process of developing implementing regulations and ADMs containing the relevant policy changes and procedures. Regulations regarding implementation of the home care provisions have been developed and will be filed on an emergency basis in May. Two administrative directives will follow. The first describing new assessment requirements will be released in late May. The second will include the fiscal management assessment process which was required by Chapter 165 of the Laws of 1991 and changed in Chapter 41 of the Laws of 1992 and will be released prior to July 1.

In the interim, for more information regarding this correspondence contact the following individuals at 1 800 342-3715:

Items I. through VII.: Rich Nussbaum, extension 3-2160; user-ID DMA041.

Items VIII. through XII.: MA Eligibility County Representative at extension 3-7581 or 212-417-4853 in New York City. Please electronically forward any comments to Elsie Kirk, user ID OME310.

Items XIII. through XVI.: Barry T. Berberich, Director, Bureau of Long Term Care, extension 3-5611 or directly at (518) 473-5611, or by electronic mail at OLT010.

Jo-Ann A. Costantino
Deputy Commissioner
Division of Medical Assistance

Attachment

Psychotropic Drugs Which Are Exempt From
Co-Payment Requirement Effective 6/1/92

Acetophenazine
Amitriptyline
Amoxapine
Benztropine
Biperidine
Bupropion
Buspirone
Chlorpromazine
Chlorprothixene
Clomipramine
Clozapine
Desipramine
Doxepin
Fluoxetine
Fluphenazine
Haloperidol
Imipramine
Lithium
Loxapine
Maprotiline
Mesoridazine
Methylephenidate
Molidone
Nortriptyline
Perphenazine
Phenelzine
Pimozide
Prochlorperazine
Promazine
Protriptyline
Thioridazine
Thiothixene
Tranylcypromine
Trazodone
Trifluoperazine
Triflupromazine
Trihexyphenidyl
Trimipramine

NEW YORK STATE

DEPARTMENT OF SOCIAL SERVICES

40 NORTH PEARL STREET, ALBANY, NEW YORK 12243-0001

MARY JO BANE
Commissioner

JO-ANN A. COSTANTINO
Deputy Commissioner
Division of Medical Assistance

May 1, 1992

Dear Home Relief Recipient:

New York State has a new law which will affect the type of medical services you receive through the Medical Assistance Program (Medicaid). This letter explains the changes. Keep this letter for future reference. The new programs are applicable only to recipients who are 21 through 64 years of age and who have not been certified as blind or disabled for Medicaid purposes and are in the Home Relief (HR) Aid category. At the time this letter was prepared, our records indicated you are an HR recipient and have not been certified as blind or disabled. If you are not sure of your aid category or you think you are disabled, call your local department of social services.

REDUCED OR FULL BENEFIT PACKAGE

Effective July 1, 1992, you will have to choose one of the following two options for receiving your medical care. If you choose **Option 1**, you may continue to receive all medical benefits that are presently available to you. If you choose **Option 2**, the types of services that are presently available to you will be reduced.

OPTION 1. THE MEDICAL CARE COORDINATOR PROGRAM or MANAGED CARE PROGRAM

If you are presently enrolled in a Health Maintenance Organization (HMO) or Managed Care Program, you will continue to be eligible to receive all of the medical benefits that are presently available to you under the Medicaid Program. You do not need to take any further action. If you are not presently enrolled in an HMO or Managed Care Program and want to do so, you may contact your local social services agency for a referral to such a medical care provider. You may enroll in such a program after July 1, 1992 but you will be eligible to receive only limited benefits under Medicaid until you enroll.

If you decide not to enroll with an HMO or Managed Care Program or if an HMO or Managed Care Program is not available in your locality, you can still retain full benefits if you agree to sign up with a physician or clinic provider who will arrange for all of your medical care and a pharmacy. This physician or clinic, known as your "medical care coordinator", will be responsible for coordinating all of the medical care you need, including making referrals to all other medically necessary services such as prescription drugs, laboratory tests, durable medical equipment, and non- emergency transportation as well as referrals to other physician specialists whom you may need to see. The pharmacy you select will be responsible for providing you with all ordered drugs. Any medical treatment which you receive which is not provided or referred by your "medical care coordinator" will not be paid for by Medicaid.

It will be your responsibility to find a physician or clinic who will act as your "medical care coordinator" and a primary pharmacy. In most cases, this can be the physician or clinic and pharmacy you already use. Once you find a medical provider, you should have them complete the attached form and mail it directly to your local department of social services.

If you decide to sign up with a physician or clinic who will act as your "medical care coordinator" and a primary pharmacy, you should have the physician or clinic and pharmacy complete the attached form and mail it to your local department of social services so that you can continue to receive the full benefit package available under Medicaid. If you do not do this by July 1, 1992 you will be eligible to receive only a limited benefit package after that date. You may sign up with a physician or clinic and pharmacy after July 1, 1992 and have the full range of Medicaid benefits made available to you.

If you cannot locate a physician or clinic and pharmacy, please call your local department of social services or this Department between the hours of 9 am to 5 pm, Monday through Friday at 1-800-541-2831 for assistance in finding appropriate providers. If this Department determines that a physician and pharmacy is not sufficiently accessible to provide you with the medical care coordination required under the new laws, then you may continue to receive the full range of medical benefits that are presently available to you. The types of services that you receive will not be reduced.

Option 2. REDUCTION IN BENEFITS OPTION

If you decide to not sign up with a medical care coordinator,an HMO or a Managed Care Program, the types of covered services you get will be reduced. Effective July 1, 1992, you will no longer be entitled to receive the following services:

- Nursing Home Care;
- Home Care, e.g. Home Health Services, Home Nursing, Personal Care Services;
- Private Duty Nursing;
- Physical Therapy, Occupational Therapy, Audiology and/or Speech Pathology Services provided by a private practicing Physical Therapist, Occupational Therapist, Audiologist or Speech Pathologist;
- Transportation Services;
- Sick Room Supplies except those for Family Planning;
- Clinical Psychology provided by a private practicing clinical psychologist; and

- Orthotic Devices including Hearing Aids and Prescription Footwear.

There are other new changes to the Medicaid Program which will affect the services that you currently receive regardless of whether you choose Option 1 or Option 2 above. These include:

NEW LIMITS ON INPATIENT CARE

New York State has a new law which limits the number of hospital inpatient days for which Medicaid will pay for Home Relief recipients who are not certified as blind or disabled. If you think that you are disabled, call your local department of social services for assistance.

Effective May 1, 1992 Medicaid will pay for up to 32 days of hospital inpatient care during your benefit year. Your benefit year will begin on May 1, 1992. If you are in the hospital for more than 32 days, you may be asked to pay the hospital for each day you stay after 32 days. Once your yearly 32 day benefit is exhausted, you may be asked to pay for any new stay during the benefit year. **A hospital may not discharge you solely because you have stayed more than 32 days in the benefit year**. If you become newly eligible after May 1, you are eligible for 32 days of care for the time period beginning with the first day of your eligibility through April 30.

If you are enrolled in a Health Maintenance Program (HMO) or other pre- paid capitation program which includes unlimited inpatient services in the rate, then there is no limitation on the number of inpatient days which you may receive.

CO-PAYMENT

Beginning June 1, 1992, Medicaid recipients age 21 or older including HR recipients will be asked to pay for part of the cost of some medical care/items. If the birthdate on your Common Benefit Identification Card is wrong, contact your local social services district immediately. This is the date used to decide if you are age 21 or older. The provider who sees you (such as your clinic or pharmacy) will ask for the co-payment. Beginning January 1, 1993, there will be a $50.00 maximum co-payment limit for pharmacy services for a three month period (January through March 1993). If you wish to take advantage of this maximum, you will have to save your pharmacy co-pay receipts starting in January of 1993 as proof that you paid the co-pay. If you are in the voluntary Medical Care Coordinator Program, co-payment **does** apply to you.

YOU WILL BE ASKED FOR CO-PAYMENT FOR:

1.**INPATIENT HOSPITAL CARE**- Each admission to a hospital (if you have to stay one or more nights) will have a $25 co-payment. This payment will be requested when you leave the hospital. The $25 is charged whether you stay one night or longer. You will be asked to pay when Medicaid is paying for some part of your hospital stay, even if Medicare is paying part. If you are sent home and then have to go back into the hospital again, you will be asked for another $25.

2.**EMERGENCY ROOM VISITS**- Each non-emergency or non-urgent visit to an emergency room will have a $3.00 co-payment.

3.**CLINIC VISITS**- Each visit to a clinic will have a $3.00 co-payment. Visits for mental health services, developmental disabilities/mental retardation services, alcohol and drug abuse services, Tuberculosis Directly Observed Therapy, family planning and Methadone Maintenance Treatment Programs (MMTP) do not require co-payments from you.

4.**PRESCRIPTION DRUGS**- Each prescription for brand-name drugs will have a $2.00 co-payment. Each prescription for generic drugs will have a $.50 co-payment. If you don't know if the prescription is for a brand-name or generic drug, ask your doctor or pharmacist. You are not required to pay toward the cost for certain psychotropic drugs used to treat or control mental illness. Your pharmacist can tell you whether the drug requires co-payment.

5.**NONPRESCRIPTION DRUGS**- Each nonprescription (over-the-counter) drug will have a $.50 co-payment.

6.**SICKROOM SUPPLIES**- Each sickroom supply will have a $1.00 co-payment. Examples are ostomy bags, heating pads, bandages, gloves, vaporizers, etc.

7.**HOME HEALTH AND LONG-TERM HOME HEALTH CARE**- Each home health care and long-term home health care service other than personal care will have a $.25 per hour or $3.00 per visit co-payment, up to a maximum of $3.00 per day per service. Your case manager can tell you which co-payment applies to the services you use.

8.**LABORATORY**- Each laboratory procedure billed by a lab to Medicaid will have a $.50 co-payment.

9.**X-RAY**- Each x-ray will have a $1.00 co-payment except for x-rays taken by your doctor in his/her office.

THERE ARE SOME EXCEPTIONS:

You are **NOT** required to pay the co-payment if:

1.You are getting the care or item and you are younger than 21 years of age.

2.You are getting the care or item and are pregnant. (If you are pregnant, have your doctor write a note that says you are pregnant to show to other providers if they ask for a co-payment.)

3.Your care is being provided by a managed care provider or a health maintenance organization (HMO).

4.The services you are receiving are for family planning (birth control or fertility), including family planning drugs or supplies such as birth control pills or condoms.

5.The care or item is for an emergency. Emergency care is care provided to patients with severe, life-threatening or potentially disabling conditions which need immediate care.

6.You are unable to pay the co-payment.

If you are unable to pay towards the cost of care tell the health care provider when you are asked for payment. The law says that providers can not refuse to give you services because you can not pay the co-payment amount. There is a toll-free telephone number to be used to report providers who refuse to give you care and tell you it is because you are unable to pay the co-payment. Please have the provider's name, address and telephone number when you make this telephone call. The telephone number will operate Monday through Friday, 9:00 AM to 5:00 PM.

The toll-free telephone number to report providers is 1-800-541-2831.

PODIATRY SERVICES

The new law also changes coverage of podiatry services under Medicaid. Effective July 1, 1992:

PATIENTS UNDER AGE 21: Medicaid will pay for care from private practicing podiatrists if a medical doctor, nurse practitioner or nurse midwife orders the care in writing.

PATIENTS AGE 21 OR OLDER WITH MEDICARE COVERAGE: There are no changes in podiatry services provided. Medicaid will continue to pay toward care for recipients with Medicare coverage.

PATIENTS AGE 21 OR OLDER WITHOUT MEDICARE COVERAGE: Medicaid will not pay private practicing podiatrists directly for care. Medically necessary foot care may be provided by some certified clinics and physicians who offer the care.

If the birthdate on your Common Benefit Identification Card is wrong, contact your local social services district immediately. This is the date used to decide if you are age 21 or older.

UTILIZATION THRESHOLD (UT) PROGRAM CHANGES

Also beginning July 1, 1992 the limit for physician/clinic visits for HR recipients 21 through 64 years of age who are not certified as blind or disabled will change from 14 visits to 10 visits per benefit year. The threshold for pharmacy benefits will change from 43 items to 28 items. The laboratory threshold will remain at 18 tests. In addition, beginning September 1, 1992 visits with psychiatrists and mental health clinic visits will change from no limits to a limit of 40 visits per benefit year. Beginning September 1, 1992 if you are in the Recipient Restriction Program, you will not be exempt from the program, but will be subject to the above threshold limits.

If you need services above your limit, ask your doctor to fill out the **THRESHOLD OVERRIDE APPLICATION**. Remember, if you do not ask for more services and you reach your limit, medical assistance will not pay for additional services except for emergency medical care, until your new benefit year begins.

FAIR HEARINGS

See the attachment for your fair hearing rights.

Sincerely,

Jo-Ann A. Costantino
Deputy Commissioner
Division of Medical Assistance
920944

Attachments

MEDICAL CARE COORDINATOR PROGRAM (MCCP)
PROVIDER SELECTION FORM

RECIPIENT NAME _____ **MEDICAID NO.**_____

PLEASE SELECT EITHER ONE PHYSICIAN OR ONE CLINIC

PRIMARY PHYSICIAN:

Name:_____
Address: _____
Telephone No. _____
MMIS Provider No: _____
Signature: _____
Date Signed: _____

PRIMARY CLINIC:

Name:_____
Address:_____
Telephone No._____
MMIS Provider No._____
Signature of Clinic Director: _____
Date Signed :_____

PRIMARY PHARMACY:

Name:_____
Address: _____
Telephone No: _____
MMIS Provider No: _____
Signature: _____
Date Signed: _____

RECIPIENT APPROVAL:

By signing this form, I volunteer to participate in the Medical Care Coordinator Program.

_____ _____
Recipient Signature Date

LOCAL SOCIAL SERVICES ACTION

The signature below confirms that as of _____, 19____, the providers indicated on this form will begin to serve as the medical care coordinator for the recipient identified above.

Signature: _____ Title _____
Telephone No: _____

FORM COMPLETION INSTRUCTIONS

The Home Relief Recipient identified on this form has volunteered for enrollment in the Medical Care Coordinator Program. The recipient is required to choose a primary physician or clinic and a primary pharmacy to serve as his/her medical care coordinators.

The following instructions should be followed when completing this form:

RECIPIENT:

1. Sign the form and bring the signed form to the providers who have agreed to be your medical care coordinators.
2. After the form has been filled out by your primary providers, return the form to the local social services agency.

PROVIDER:

1. Complete the appropriate section of the form and return to the recipient. Please print legibly.

LOCAL SOCIAL SERVICES AGENCY:

1. Sign the form where indicated and include the effective date the provider will begin to serve as the primary provider.
2. Make appropriate changes to WMS.
3. Send a copy of the form to the physician or clinic and the pharmacy. Also send a copy to the recipient.
4. Retain a copy of the completed form for the recipient case record.

NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES
40 NORTH PEARL STREET, ALBANY, NEW YORK 12243-0001

MARY JO BANE
Commissioner

JO-ANN A. COSTANTINO
Deputy Commissioner
Division of Medical Assistance

May 1, 1992

Dear Medicaid Recipient:

New York State has new laws which have changed the Medicaid Program. This letter is your official notice about the changes and it is important that you keep this letter for future reference.

The following changes will affect you:

- Beginning on June 1, 1992 Medicaid recipients age 21 or older will be asked to pay for part of the cost of some medical care. This is called a co-payment or co-pay.
- Beginning on July 1, 1992 Medicaid will no longer directly pay for care from podiatrists except for services to children under age 21 and to Medicare beneficiaries.
- Beginning on September 1, 1992 the utilization threshold level for pharmacy services will change. This is the program that gives you a certain number of services, and you have to ask your doctor to apply for more if you need more.

CO-PAYMENT

Medicaid recipients age 21 or older will be asked to pay for part of the cost of some medical care/items. If the birthdate on your Common Benefit Identification Card is wrong, contact your local social services district immediately. This is the date used to decide if you are age 21 or older. The provider who sees you (such as your clinic or pharmacy) will ask for the co-payment. Beginning January 1, 1993, there will be a $50.00 maximum co- payment limit for pharmacy services for a three month period (January through March 1993). If you wish to take advantage of this maximum, you will have to save your pharmacy co-pay receipts starting in January of 1993 as proof that you paid the co-pay. If you are eligible for Medicaid with a spenddown, you should save all co-pay receipts since they can count towards your spend down amount.

YOU WILL BE ASKED FOR CO-PAYMENT FOR:

1. **INPATIENT HOSPITAL CARE**- Each admission to a hospital (if you have to stay one or more nights) will have a $25 co-payment. This payment will be requested when you leave the hospital. The $25 is charged whether you stay one night or longer. You will be asked to pay when Medicaid is paying for some part of your hospital stay, even if Medicare is paying part. If you are sent home and then have to go back into the hospital again, you will be asked for another $25.

2. **EMERGENCY ROOM VISITS**- Each non-emergency or non-urgent visit to an emergency room will have a $3.00 co-payment.

3. **CLINIC VISITS**- Each visit to a clinic will have a $3.00 co-payment. Visits for mental health services, developmental disabilities/mental retardation services, alcohol and drug abuse services, Tuberculosis Directly Observed Therapy, family planning and Methadone Maintenance Treatment Programs (MMTP) do not require co-payments from you.

4. **PRESCRIPTION DRUGS**- Each prescription for brand-name drugs will have a $2.00 co-payment. Each prescription for generic drugs will have a $.50 co-payment. If you don't know if the prescription is for a brand-name or generic drug, ask your doctor or pharmacist. You are not required to pay toward the cost for certain psychotropic drugs used to treat or control mental illness. Your pharmacist can tell you whether the drug requires co-payment.

5. **NONPRESCRIPTION DRUGS**- Each nonprescription (over-the-counter) drug will have a $.50 co-payment.

6. **SICKROOM SUPPLIES**- Each sickroom supply will have a $1.00 co-payment. Examples are ostomy bags, heating pads, bandages, gloves, vaporizers, etc.

7. **HOME HEALTH AND LONG-TERM HOME HEALTH CARE**- Each home health care and long-term home health care service other than personal care will have a $.25 per hour or $3.00 per visit co-payment, up to a maximum of $3.00 per day per service. Your case manager can tell you which co-payment applies to the services you use.

8. **LABORATORY**- Each laboratory procedure billed by a lab to Medicaid will have a $.50 co-payment.

9. **X-RAY**- Each x-ray will have a $1.00 co-payment except for x-rays taken by your doctor in his/her office.

THERE ARE SOME EXCEPTIONS:

You are **NOT** required to pay the co-payment if:

1.You are getting the care or item and you are younger than 21 years of age.

2.You are getting the care or item and are pregnant. (If you are pregnant, have your doctor write a note that says you are pregnant to show to other providers if they ask for a co-payment.)

3.Your care is being provided by a managed care provider or a health maintenance organization (HMO).

4.The services you are receiving are for family planning (birth control or fertility), including family planning drugs or supplies such as birth control pills or condoms.

5.The care or item is for an emergency. Emergency care is care provided to patients with severe, life-threatening or potentially disabling conditions which need immediate care.

6.You are unable to pay the co-payment.

If you are unable to pay towards the cost of care tell the health care provider when you are asked for payment. The law says that providers can not refuse to give you services because you can not pay the co-payment amount. There is a toll-free telephone number to be used to report providers who refuse to give you care and tell you it is because you are unable to pay the co-payment. Please have the provider's name, address and telephone number when you make this telephone call. The telephone number will operate Monday through Friday, 9:00 AM to 5:00 PM.

The toll-free telephone number to report providers is 1-800-541-2831.

PODIATRY SERVICES

PATIENTS UNDER AGE 21: Medicaid will pay for care from private practicing podiatrists if a medical doctor, nurse practitioner or nurse midwife orders the care in writing.

PATIENTS AGE 21 OR OLDER WITH MEDICARE COVERAGE: There are no changes in podiatry services provided. Medicaid will continue to pay toward care for recipients with Medicare coverage.

PATIENTS AGE 21 OR OLDER WITHOUT MEDICARE COVERAGE: Medicaid will not pay private practicing podiatrists directly for care. Medically necessary foot care may be provided by some certified clinics and physicians who offer the care.

If the birthdate on your Common Benefit Identification Card is wrong, contact your local social services district immediately. This is the date used to decide if you are age 21 or older.

UTILIZATION THRESHOLD (UT) PROGRAM CHANGES

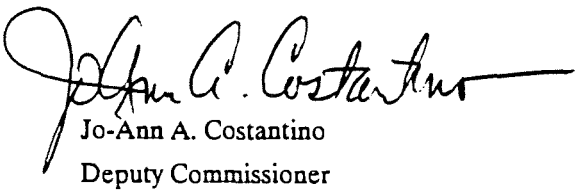
Beginning September 1, 1992, the Utilization Threshold limit for pharmacy services will change from 60 items to 40 items for recipients under age 21, or age 65 or older; certified disabled; certified blind; or single caretakers of a child under age 18. The current thresholds for physicians, clinics and laboratories will remain the same. Beginning September 1, 1992, if you are in the Recipient Restriction Program, you will not be exempt from the program, but will be subject to the threshold limits.

If you need services above your limit make sure that you ask your doctor to fill out the **Threshold Override Application**. Remember, if you do not ask for more services and you reach your limit, Medical Assistance will not pay for additional services except for emergency medical care, until your new benefit year begins. For complete information, refer to your Medical Assistance Utilization Threshold fact sheet.

FAIR HEARINGS

See the attachment for your fair hearing rights.

Sincerely,



Jo-Ann A. Costantino
Deputy Commissioner
Division of Medical Assistance
920943

Attachment

MA Chapter 41 Notice

RIGHT TO A CONFERENCE: You may have a conference to review this action **if you think we made a mistake about your date of birth, or your aid category (HR, ADC or SSI), or whether you are in a managed care program or HMO - but not just because you believe the new law is unfair.** If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling your worker or by sending a written request to your local social services department. This number is used only for asking for a conference. It is not the way you request a fair hearing. If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid-continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

FAIR HEARING REQUEST: These limits on your Medicaid coverage are based on a change in State law. **You have the right to have a fair hearing if you think we made a mistake about your date of birth, or your aid category (HR, ADC or SSI), or whether you are in a managed care program or HMO - but not just because you believe the new law is unfair.** The hearing officer at the hearing may determine that you do not have a right to a hearing or a continuation of Medicaid, if the only issue at the hearing is the change in State law. You may request a State fair hearing by:

(1) Telephoning: (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 417-6550

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County:** (716) 847-3877.

If you live in: **Alegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or Yates County:** (716) 238-8282.

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins or Tioga County:** (315) 428-4117.

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington or Westchester County:** (518) 474-8781

OR

(2) **Writing:** By sending a copy of this notice completed, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. **PLEASE KEEP A COPY FOR YOURSELF.**

I want a fair hearing. The Agency's action is wrong because:

_____

_____

Signature of Client_____Date_____Case #_____

Address: _____

Telephone # (_____) -_____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, or medical verification that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date stated in this notice you will receive the benefits being disputed until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover the cost of any Medicaid benefits that you should not have received. If you want to avoid this possibility, check the box below to indicate that you do not want your aid continued, and send this page along with your hearing request. If you do check the box , the action described above will be taken on the effective date listed above.

☐ I agree to have the action taken on my Medicaid benefits, as described in this notice, prior to the issuance of the fair hearing decision.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling your worker.

ACCESS TO RECORDS/ INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call your worker or send a written request to your local social services department.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case record and/or additional copies of documents, you may call your worker or write to your local social services department.

STATE OF NEW YORK

CHAPTER 41 OF THE LAWS OF 1992

S. 6806--A SIGNED APRIL 2, 1992 A. 9306--A

SENATE - ASSEMBLY

January 23, 1992

IN SENATE -- A BUDGET BILL, submitted by the Governor pursuant to article seven of the Constitution -- read twice and ordered printed, and when printed to be committed to the Committee on Finance -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

IN ASSEMBLY -- A BUDGET BILL, submitted pursuant to article seven of the Constitution -- read once and referred to the Committee on Ways and Means -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to contain health care provider reimbursement rates; to amend the public health law, the social services law, the mental hygiene law and chapter 938 of the laws of 1990 amending the public health law, the social services law and the mental hygiene law, relating to assessing certain health care providers, in relation to assessments on certain health care providers; to authorize the transfer of certain funds to the department of social services medical assistance - local assistance appropriation from the bad debt and charity care pools; to amend chapter 166 of the laws of 1991, amending the tax law and other laws relating to deduction or credit by a shareholder and related provisions; to amend the social services law, in relation to payments and services under the medical assistance program; and to repeal certain provisions of the public health law, the social services law and chapter 938 of the laws of 1990 amending the public health law, the social services law and the mental hygiene law, relating to assessing certain health care providers, relating thereto; to amend the public health law and the social services law, in relation to assessing certain health care providers to authorize the transfer of certain funds and payments and services under the medical assistance program; in relation to the definition of medical assistance and eligibility therefor, establishment of a system of co-payments for medical assistance and utilization of home care and personal care services; amending the estates, powers and trusts law, in relation to disposition in trust for use; the surrogate's court procedure act, in relation to debtor debt; the penal law, in relation to medical assistance authorization card; and to amend chapter 266 of the laws of 1986 amending the civil practice law and rules and other laws relating to

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malpractice and professional medical conduct; to amend the social services law, in relation to strengthening recipient employment service requirements and incentives, eliminating non-essential assistance, and controlling fraud and abuse and further in relation to the payment of security deposits for public assistance recipients and the character of home relief; to amend the executive law and the social services law, in relation to creating an office of welfare inspector general; to amend the domestic relations law, the family court act, the judiciary law and the social services law, in relation to child support establishment and to repeal subdivision ten of section 111-b of the social services law, relating thereto and to amend the domestic relations law, the family court act, in relation to support arrears/past due child support and to the enforceability; to amend the social services law, in relation to establishing fingerprint identification demonstration programs in the counties of Rockland and Onondaga for home relief recipients; and to amend the executive law and chapter 829 of the laws of 1990 amending the executive law relating to the elderly pharmaceutical insurance coverage program, in relation to the elderly pharmaceutical insurance coverage program and rebate agreements with drug manufacturers; to amend the public health law, in relation to continuing rate adjustments for certain hospitals and to provide for the repeal of certain provisions of this act at the expiration thereof

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

Section 1. Notwithstanding any inconsistent provision of law or regulation to the contrary, maximum daily rates of payment, excluding the allowable costs of transportation, to residential health care facilities for adult day services provided in a 24-hour period on or after July 1, 1992 to persons eligible for payments made by state governmental agencies determined in accordance with article 28 of the public health law shall be sixty-five percent of the sponsoring facility's residential health care facility per diem rate on January 1, 1990 with the operating cost component trended to the rate period by the trend factor applicable to the sponsoring facility. The department shall survey adult day care providers to determine the type and cost of services provided.

§ 2. The commissioner of health shall convene a work group to review and make recommendations regarding the provision of and payment for adult day services provided through residential health care facilities. Such work group shall consist of representatives from the departments of health and social services, provider associations, adult day services programs and consumers. Such review shall include an examination of issues related to: (a) establishment of a payment mechanism which integrates payment for services, registrant functional needs, and service utilization; or assessment of other alternative payment methodology; (b) development of an appropriate assessment instrument for determining registrant social and health needs and estimated incremental costs related to staff time to complete the form provided however that the Minimum Data Set (MDS+), or its successor, shall not be used as the registrant assessment instrument for adult day services programs sponsored by residential health care facilities; (c) review of admission and retention regulatory requirements; and (d) assessment of cost-effective methods for capital reimbursement. On or before January 15, 1993, the commissioner of health shall submit a report to the governor, the majority leader of the senate and the speaker of the assembly on the progress of

the comptroller and repayed from the general fund no later than December thirty-first, nineteen hundred ninety-three.]

(ii) The remaining balance shall be reserved and accumulated from year to year by the commissioner from priority distributions to general hospitals in accordance with the rules and regulations adopted by the council and approved by the commissioner: (A) to assist in offsetting losses from bad debt and the costs of charity care in providing existing or expanded priority health services to the medically indigent or medically underserved in urban and rural areas including, but not limited to, services for pregnant women, services for children under the age of six, and services related to acquired immune deficiency syndrome; (B) regional quality assurance demonstration projects; and (C) hospital severity of illness measurement demonstration projects.

Notwithstanding any provision of the law to the contrary, a sum not to exceed five million dollars collected in the period beginning January first, nineteen hundred eighty-eight and ending December thirty-first, nineteen hundred ninety shall be reallocated from funds otherwise distributed in accordance with this subparagraph and credited to the department of social services' medical assistance program general fund local assistance account; provided, however, that for purposes of calculations pursuant to chapter two of the laws of nineteen hundred eighty-eight and pursuant to subdivisions (a), (b) and (c) of section eleven of chapter seven hundred three of the laws of nineteen hundred eighty-eight, such reallocated funds shall be deemed distributed in accordance with this subparagraph. [However, should the reallocation result in insufficient moneys to meet the obligations of the programs within the amounts made available by chapter two of the laws of nineteen hundred eighty-eight and pursuant to chapter seven hundred three of the laws of nineteen hundred eighty-eight, the director of the division of budget is hereby authorized to and within thirty days shall allocate from the general fund such funds as are necessary to meet the obligations, but not to exceed the amount reallocated, to be distributed in accordance with this subparagraph. Further, that the amount reallocated, less any funds repayed due to insufficient funds in the programs, shall be encumbered by the state comptroller before the end of each fiscal year, and for any fiscal year commencing on or after April first, nineteen hundred ninety-one but ending with the fiscal year beginning on April first, nineteen hundred ninety-three where the governor fails to submit a budget bill containing an appropriation to provide for the programs or the legislature fails to appropriate such amount in the budget bill submitted by the governor for such fiscal year, the amount reallocated and encumbered shall be payable forthwith to such programs on the fifteenth day of May of such year, in the manner described by law, except that for the fiscal year beginning April first, nineteen hundred ninety-three such reallocation shall be encumbered by the comptroller and repayed from the general fund no later than December thirty-first, nineteen hundred ninety-three.]

§ 60. The opening paragraph of subdivision 2 of section 365-a of the social services law, as amended by chapter 110 of the laws of 1971, is amended to read as follows:

"Medical assistance" shall mean payment of part or all of the cost of <u>medically necessary medical, dental and remedial</u> care, services and supplies<u>, as authorized in this title or the regulations of the department,</u> which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with [his] <u>such person's</u> capacity for normal ac-

tivity, or threaten some significant handicap and which are furnished an eligible person [is] in accordance with this title [,] and the regulations of the department. Such care, services and supplies shall include [, but need not be limited to] the following medical care, services and supplies, together with such medical care, services and supplies provided for in subdivisions three, four and five of this section, and such medical care, services and supplies as are authorized in the regulations of the department:

§ 61. Notwithstanding subdivision 2 of section 365-a of the social services law, "medical assistance" shall include court-ordered care, services or supplies, other than medical care, services or supplies, heretofore ordered by a court to be provided to a recipient of medical assistance.

§ 62. Paragraphs (a) and (l) of subdivision 2 of section 365-a of the social services law, as amended by chapter 165 of the laws of 1991, are amended and a new subdivision 8 is added to read as follows:

(a) services of qualified physicians, dentists [to the extent authorized by paragraph (e) herein], nurses except that private duty nursing shall be provided subject to section three hundred sixty-seven-l of this chapter, and private duty nursing services shall be further subject to the provisions of section three hundred sixty-seven-o of this chapter, optometrists, [podiatrists] and other related professional personnel;

(l) care and services of podiatrists which care and services shall only be provided upon referral by a physician, nurse practitioner or certified nurse midwife in accordance with the program of early and periodic screening and diagnosis established pursuant to subdivision three of this section or to persons eligible for benefits under title XVIII of the federal social security act as qualified medicare beneficiaries in accordance with federal requirements therefor and private duty nurses which care and services shall only be provided in accordance with regulations of the department of health and subject to the provisions of section three hundred sixty-seven-l of this title.

8. (a) Any person twenty-one years of age or older eligible for benefits under this title pursuant to section three hundred sixty-six of this article only as a result of being eligible for or in receipt of home relief shall receive the services specified in subdivision two of this section, provided that:

(i) such person shall receive the services listed in paragraphs (d), (e), (h), (j) and (l) of subdivision two of this section, optometric services as described in paragraph (a) of subdivision two of this section, audiology as described in paragraph (n) of subdivision two of this section, clinical psychologists, orthotics, sick room supplies and inpatient services in a nursing home as described in paragraph (b) of subdivision two of this section, but only if such person is enrolled in one of the following programs, or if there is no provider affiliated with any such program who is sufficiently accessible to the recipient as to reasonably provide services to the recipient, in accordance with departmental regulations:

(A) a health maintenance organization or other entity which provides comprehensive health services;

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(B) a managed care program or other primary provider program, as specified by the department; or

(C) a voluntary medical care coordinator program. For the purposes of this subdivision, a voluntary medical care coordinator program shall mean a program established in accordance with departmental regulations to enroll medical assistance recipients with primary physicians, diagnostic and treatment centers and hospital outpatient departments and primary pharmacies which shall provide or refer the recipient to medically necessary services pursuant to this section and shall further coordinate the utilization of those services to assure the appropriate and cost-effective delivery of medical assistance.

(ii) in no case shall payment be made for more than thirty-two days of in-patient services, excepting in-patient services in a nursing home as such term is defined in section twenty-eight hundred one of the public health law, in any twelve month consecutive period unless such services are part of a full capitation program, and provided, further, that in no event shall an in-patient facility providing in-patient services described in paragraph (b) of subdivision two of this section discharge such person solely as a result of his or her having received the maximum number of his or her in-patient service days for which payment is available pursuant to this title.

§ 63. Paragraph (d) of subdivision 2 of section 365-a of the social services law, as amended by chapter 165 of the laws of 1991, is amended to read as follows:

(d) home health services provided in a recipient's home and prescribed by a physician subject to the provisions of section three hundred sixty-seven-j of this title including[: (i)] services of a nurse provided on a part-time or intermittent basis rendered by an approved home health agency or if no such agency is available, by a registered nurse, licensed to practice in this state, acting under the written orders of a physician[; (ii)] and home health aide service provided by an approved home health agency;

§ 64. The opening paragraph of paragraph (a) of subdivision 2 of section 366 of the social services law, as amended by chapter 77 of the laws of 1977, is amended and a new subdivision 8 is added to read as follows:

The following income and resources shall be exempt and shall [neither] not be taken into consideration [nor required to be applied toward the payment or part payment of the cost of] in determining a person's eligibility for medical care [and], services and supplies available under this title:

8. Notwithstanding any inconsistent provision of this chapter or any other law to the contrary, income and resources which are otherwise exempt from consideration in determining a person's eligibility for medical care, services and supplies available under this title, shall be considered available for the payment or part payment of the costs of such medical care, services and supplies as required by federal law and regulations.

§ 65. Subparagraph 4 of paragraph (a) of subdivision 2 of section 366 of the social services law, as separately amended by chapters 32 and 588 of the laws of 1968, is amended to read as follows:

(4) savings in amounts equal to at least one-half of the [appropriate income exemptions allowed] 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;

§ 66. Subdivisions 4 and 5 of section 365-g of the social services law, subdivision 4 as added by chapter 938 of the laws of 1990 and subdivision 5 as amended by chapter 165 of the laws of 1991, are amended to read as follows:

4. Utilization thresholds established pursuant to this section shall not apply to the following services:

(a) clinic and other outpatient services, as follows:

(i) mental health services provided pursuant to paragraph (c) of subdivision two of section three hundred sixty-five-a of this chapter, alcoholism services, substance abuse services, mental retardation [services] and developmental disabilities services provided in clinics certified under article twenty-eight of the public health law, or article twenty-three or article thirty-one of the mental hygiene law provided to persons eligible for medical assistance by reason other than their being eligible for home relief and continuing treatment and continuing day treatment certified under article thirty-one of the mental hygiene law provided to persons eligible for medical assistance solely by reason of their being eligible for home relief; and

(ii) alcoholism services, substance abuse services, mental retardation services and developmental disabilities services provided in clinics certified under article twenty-eight of the public health law, or article twenty-three or article thirty-one of the mental hygiene law provided to persons eligible for medical assistance by reason of their being eligible for home relief; and

(iii) services performed by an article twenty-eight hospital or diagnostic and treatment center on an ambulatory basis upon the order of a qualified practitioner to test, diagnose or treat the recipient.

(b) physician services, as follows:

(i) psychiatric services provided to persons eligible for medical assistance by reason other than their being eligible for home relief; and

(ii) anesthesiology services.

5. Utilization thresholds established pursuant to this section shall not apply to services, even though such services might otherwise be subject to utilization thresholds, when provided as follows:

(a) through a managed care program;

(b) subject to prior approval or prior authorization;

(c) as family planning services;

(d) [under the recipient restriction program;

(e)] as methadone maintenance services;

[(f)] (e) on a fee-for-services basis to in-patients in general hospitals certified under article twenty-eight of the public health law or article thirty-one of the mental hygiene law and residential health care facilities, with the exception of podiatrists' services;

[(g)] (f) for hemodialysis; or

[(h)] (g) through or by referral from a preferred primary care provider designated pursuant to subdivision twelve of section twenty-eight hundred seven of the public health law.

§ 67. Section 367-a of the social services law is amended by adding a new subdivision 12 to read as follows:

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12. Notwithstanding any inconsistent provision of law or regulation to the contrary, the commissioner shall reduce payments for in-patient services for patients that exceed the limitations on covered days of such services pursuant to paragraph (b) of subdivision eight of section three hundred sixty-five-a of this title: (a) to exclude, for per diem unit of service based payments, payments for days of care provided to a patient that exceed such limitations; and (b) to exclude, for case based unit of service payments, a percentage of the case based payment amount based upon the ratio of the number of days of care covered by the case based rate of payment actually provided to a patient that exceed such limitations to the total number of days of care covered by the case based rate of payment actually provided to such patient, expressed as a percentage.

§ 68. Subparagraph (iv) of paragraph (e) of subdivision 1 of section 367-j of the social services law, as added by chapter 165 of the laws 1991, is amended to read as follows:

(iv) home health services are appropriate for the recipient's functional needs and [the recipient's living and working arrangements, can maintain the recipient in the home, and can be reasonably provided or, based on] that institutionalization is contraindicated, based on a review by the certified home health agency of the recipient's medical case history, [that] including a certified statement from the recipient's physician on a form required by the department and the department of health describing the potential impact of institutionalization which has been reviewed by a residential health care facility to determine if institutionalization would result in a diminishing of the recipient's ability to perform the activities of daily living;

§ 69. Subparagraph (v) of paragraph (e) of subdivision 1 of section 367-j of the social services law is REPEALED and subparagraph (vi) of such paragraph is relettered subparagraph (v) and amended to read as follows:

(v) the [local social services district] certified home health agency determines in the event the recipient lives with someone who would require services in the recipient's absence, that the cost for services for both persons, if either or both are institutionalized, would equal or exceed the cost for continued home health services for the recipient and for services to such other person.

§ 70. Subdivision 2 of section 367-j of the social services law, as added by chapter 165 of the laws of 1991, is amended to read as follows:

2. (a) Certified home health agencies shall assess all recipients, to determine, the following:

(i) [eligibility for hospice services, and unless medically contraindicated by a recipient's physician, notify recipients of such services if available in the district and assisting the social services district with referrals to hospice if a recipient so chooses;

(ii)] that the provision of home health services are provided according to the plan of care and can maintain the recipient's health and safety in the home as defined by the department of health in regulation;

[(iii)] (ii) whether the functional needs and living and working arrangements, of recipients receiving home health services solely for the purposes of monitoring such recipients, can be appropriately and more cost-effectively monitored through the provision of personal emergency response system services available in the district;

[(iv)] (iii) whether the functional needs and living and working arrangements, of home health services recipients can be appropriately and more cost-effectively maintained through the provision of shared aides;

[(v)] (iv) whether home health services recipients requiring only personal care, or an appropriate substitute, and that do not require, as part of a routine plan of care, part-time or intermittent nursing or other therapeutic services, can be appropriately and more cost-effectively served through the provision of personal care services, unless such services are otherwise available in the district;

[(vi)] (v) whether home health services can be appropriately and more cost-effectively provided to the recipient by the agency in cooperation with an adult day health program or a clinic rather than on a fee for service basis, provided however, that such program or clinic is geographically accessible to the recipient;

[(vii)] (vi) whether home health services recipients can be appropriately and more cost-effectively served through other long-term care services, including but not limited to the long-term home health care program, assisted living program and enriched housing program; and

(vii) whether home health services can be appropriately and more cost-effectively provided under a patient managed home care program consistent with section three hundred sixty-five-f of this title.

(b) If a certified home health agency determines that the recipient can be appropriately and more cost-effectively served through the provision of services or settings described in subparagraphs (ii), (iii), (iv), (v), (vi) and (vii) of paragraph (a) of this subdivision then the certified home health agency shall first consider the use of such services or settings in the development of a plan of care [for] and the recipient shall be required to use such services or settings in lieu of home health services for the maximum reduction in the need for home health services or other long-term care services.

(c) The certified home health agency must have a written agreement with any hospice which is available in the service area of the certified home health agency. Such agreement must specify the procedures for notifying recipients believed eligible, unless medically contraindicated by a recipient's physician, of the availability of hospice services and for referring recipients to such hospice, if a recipient so chooses.

§ 71. Subparagraph (iv) of paragraph (d) of subdivision 1 of section 367-k of the social services law, as added by chapter 165 of the laws of 1991, is amended to read as follows:

(iv) personal care services are [most] appropriate for the recipient's functional needs and [the recipient's living and working arrangements; the social services official reasonably expects that the services can maintain the recipient in the home; and the services can be reasonably provided or, based on] that institutionalization is contraindicated, based on a review by the social services district of the recipient's medical case history[, that] including a certified statement from the recipient's physician on a form required by the department and the department of health describing the potential impact of institutionalization which has been reviewed by a residential health care facility to determine if institutionalization would result in a diminishing of the recipient's ability to perform the activities of daily living;

§ 72. Subparagraph (v) of paragraph (d) of subdivision 1 of section 367-k of the social services law is REPEALED and subparagraph (vi) of such paragraph is relettered subparagraph (v).

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

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§ 73. Subdivision 2 of section 367-k of the social services is amended to read as follows:

2. (a) Social services districts' shall assess all recipients to determine the following:

(i) [eligibility for hospice services and, unless medically contraindicated by a recipient's physician, notify recipients of such services if available in the district and make referrals to hospice if a recipient so chooses;

(ii)] that the provision of personal care services are provided according to the plan of care and can maintain the recipient's health and safety in the home as defined by the department of health in regulation;

[(iii)] (ii) whether the functional needs and living and working arrangements, of recipients receiving personal care services solely for the purposes of monitoring such recipients, can be appropriately and more cost-effectively monitored through the provision of personal emergency response system services available in the district;

[(iv)] (iii) whether the functional needs and living and working arrangements, of personal care services recipients can be appropriately and more cost-effectively maintained through the provision of shared aides;

[(v)] (iv) whether a personal care recipient requiring, as part of a routine plan of care, part-time or intermittent nursing or other therapeutic service provided by a provider, except for the provision of services expected to be required on a short-term basis or nursing provided to a medically stable recipient, can be appropriately and more cost-effectively served through the provision of certified home health services; and

[(vi)] (v) whether personal care recipients can be appropriately and cost-effectively served through other long-term care services, including but not limited to, the long-term home health care program, assisted living program and enriched housing program; and

(vi) whether personal care services can be appropriately and more cost-effectively provided under a patient managed home care program consistent with section three hundred sixty-five-f of this title.

(b) If a social services district determines that the recipient can be appropriately and more cost-effectively served through the provision of services or settings described in subparagraphs (ii), (iii), (iv), (v) and (vi) of paragraph (a) of this subdivision then the social services district shall first consider the use of such services or settings in the development of a plan of care for the recipient shall be required to use such services or settings in lieu of personal care services or for maximum reduction in the need for home health services or other long-term care services.

(c) The social services district must have a written agreement with any hospice which is available in the district. Such agreement must specify the procedures for notifying recipients believed eligible, unless medically contraindicated by a recipient's physician, of the availability of hospice services and for referring recipients to such hospice, if a recipient so chooses.

§ 74. Subparagraph (iv) of paragraph (d) of subdivision 2 of section 367-1 of the social services law, as added by chapter 165 of the laws of 1991, is amended to read as follows:

(iv) the private duty nursing services are [most] appropriate for the recipient's functional needs and [the recipient's living and working arrangements, can maintain the recipient in the home and can be reasonably provided or, based on] that institutionalization is contraindicated,

based on a review by the social services district of the recipient's medical case history, [that] including a certified statement from the recipient's physician on a form required by the department and the department of health describing the potential impact of institutionalization which has been reviewed by a residential health care facility to determine if institutionalization would result in a diminishing of the recipient's ability to perform the activities of daily living;

§ 75. Subparagraph (v) of paragraph (d) of subdivision 2 of section 367-1 of the social services law is REPEALED and subparagraph (vi) of such paragraph is relettered subparagraph (v).

§ 76. Paragraph (b) of subdivision 3 of section 367-1 of the social services law, as added by chapter 165 of the laws of 1991, is amended to read as follows:

(b) If a social services district determines that the recipient can be appropriately and more cost-effectively served through the provision of services or settings described in subparagraphs (iii) and (iv) of paragraph (a) of this subdivision then the social services district shall first consider the use of such services or settings in the development of a plan of care for the recipient shall be required to use such services or settings in lieu of private duty nursing or for maximum reduction in the need for home health services or other long-term care services.

§ 77. The departments of health and social services shall encourage the development of shared aide programs among providers which demonstrate the ability to provide services with the greatest economies of scale.

§ 78. The social services law is amended by adding a new section 367-o to read as follows:

§ 367-o. Instruments for home care assessment. 1. The commissioner and the commissioner of health, shall establish and may periodically revise instruments for home care screening, referral, assessment, eligibility determination, and discharge, which shall be used by certified home health agencies, providers of long term home health care programs, providers of AIDS home care programs, providers of private duty nursing, and providers of personal care services to determine a recipient's eligibility for and the nature and amount of such services to be provided to the recipient. Such instrument shall:

(a) allow for use by hospital discharge planners that portion of the instrument necessary to direct a hospitalized recipient into the home care program which is expected to meet their assessed needs most appropriately and cost-effectively; and to the extent possible and appropriate, direct

(i) to a certified home health agency recipients who require therapeutic and/or skilled services and/or require clinical management;

(ii) to a long term home health care program, if such program is available in their area, recipients who are expected to require care over an extended period and whose condition meets criteria for medical eligibility in a residential health care facility, whose condition requires services beyond care and nurse monitoring, or whose condition is determined to be medically unstable;

(iii) to a personal care services program recipients whose condition is determined to be medically stable; and

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(iv) to a hospice available within their area recipients for whom it is not medically contraindicated and if desired by the recipient;

(b) assess the patient's characteristics and service needs, including health, social and environmental needs and whether home care services are appropriate and can be safely provided to the recipient, and shall be used to refer recipients to the home care program which most appropriately and cost effectively meets their needs, or other long term care service which is deemed appropriate for the recipient;

(c) confirm the recipient's eligibility for the program to which the recipient has been referred or direct the recipient to the home care program which most appropriately and cost-effectively meets his or her needs;

(d) consider factors that include but are not limited to the following: the recipient's ability to perform activities of daily living, the recipient's mental and physical ability to direct his or her own care and to summon assistance, the recipient's health and rehabilitation needs, as well as the availability, willingness and ability of others to provide care. When it is determined that the recipient is not physically or mentally able to direct their own care or to summon assistance, the instrument shall consider whether the recipient has someone who is available, able and willing to make decisions on behalf of the recipient;

(e) specify the maximum number of hours per month, or the equivalent thereof, which will be paid for under the medical assistance program provided, however that the recipient's health and safety will not be jeopardized;

(f) serve as a basis for the plan of care and consider the relationship between all the services provided by the home care providers to which the recipient is referred, all other home care services available in the area as defined in this subdivision, the availability of informal supports to provide care, the sources of support suggested by the recipient or the recipient's representative and potential for medicare coverage of recipient care needs;

(g) not apply to a recipient requiring care for sixty continuous days or less; and

(h) be used directly by certified home health agencies, long term home health care programs, or, if personal care services are appropriate, by the social services district or its designee, which may include an agency under contract with the social services district to provide personal care services or a certified home health agency, under conditions specified by the department.

2. The instruments established, or revised, pursuant to subdivision one of this section shall be employed for the following categories of recipients and such services shall not be authorized for more than the maximum hours of service per month, or the equivalent thereof, per recipient, based on such instrument regardless of the number of monthly service hours, or their equivalent, if any, currently authorized for a recipient:

(a) recipients who initially are authorized for such services on or after July first, nineteen hundred ninety-two;

(b) all recipients, upon the periodic reassessment of their care plan; and

(c) recipients who currently receive more than one hundred fifty-six hours, or its equivalent, of such services per month; provided, however, that the department shall require the reassessment of such recipients utilizing the instrument; notify such recipients of the required reas-

sessment, as determined by the department; and limit payments for such services to the equivalent of one hundred fifty-six hours per month for those recipients who fail to comply with such reassessment requirement until such recipients are reassessed provided, however, the recipients' health and safety is not jeopardized.

3. Notwithstanding subdivision two of this section, any maximum hours per month limitations imposed as a result of use of the assessment instrument shall not apply with respect to recipients of long term home health care program services.

4. The provisions of this section shall not apply to individuals receiving services authorized under subdivisions six and seven of section three hundred sixty-six of this chapter.

§ 79. The social services law is amended by adding a new section 367-n to read as follows:

§ 367-n. Delegation of responsibility by social services districts. 1. The departments of social services and health shall by September first, nineteen hundred ninety-two develop delegation protocols whereunder the social services districts delegate activities related to home care services which currently are the responsibility of local districts to providers of home health and personal care services or other entities. Such protocols shall address the required assessment form; provide for review of fiscal assessments; arrange for alternative placements; care plan management; and shall reflect improved social services district activities, including, but not limited to, medical assistance eligibility determinations, audits, review of high cost cases, and such other matters relating to delegation as determined by the commissioners.

2. By January first, nineteen hundred ninety-three, districts must submit to the department a plan for the delegation of responsibilities to one or more providers or other entities in accordance with the delegation protocols of the departments of health and social services. Nothing shall preclude a district from delegating responsibilities to some but not all providers operating within the district.

3. Notwithstanding subdivision two of this section, a district may submit to the department in lieu of a delegation plan, a request for a waiver of the requirement of such subdivision two, provided it furnishes the department with the basis for such waiver. The commissioner is authorized in his or her discretion, to grant or deny such waiver requests.

4. The plan for delegation, which must be approved or disapproved within ninety days of receipt of the plan, must be reviewed in accordance with the delegation protocols and also reviewed in accordance with the following:

(a) The department of health shall review whether licensed or certified home health agencies to whom it is proposed to delegate responsibilities have complied with department of health standards as outlined in article thirty-six of the public health law.

(b) The department shall review any department audits, reports or other materials regarding the agencies to whom it is proposed to delegate responsibilities to determine if the agency has engaged in any unacceptable practices as defined in department regulations.

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5. The department and the department of health shall be responsible for auditing the performance of the delegated tasks by the provider agency.

6. The delegation of responsibility may be revoked by the department if the agency fails to perform any of the delegated responsibilities according to standards established in the regulations.

§ 80. The departments of health and social services shall jointly establish a group comprised of representatives of the state council on home care services, consumer representatives, representatives of social services districts, representatives of home and personal care workers and representatives of certified home health agencies, personal care providers, and long term home health care providers, to advise the departments regarding the development and implementation of a common assessment instrument and maximum hours of care paid for under the medical assistance program as based on the instrument and as it reflects the recipient's needs, health and safety, and solicit public input. The departments must give the advisory group adequate notice and consultation of any substantive changes made after July 1, 1992 in the assessment instrument.

§ 81. The departments of social services and health shall submit to the legislature no later than June 1, 1992, a copy of the home care and personal care assessment instrument and the basis for arriving at the maximum hours paid under the medical assistance program developed pursuant to section 367-o of the social services law. Such departments shall also jointly issue an interim report to the governor and the legislature no later than June 1, 1993 which shall report on the effectiveness of this act as it relates to the utilization and cost of Medicaid funded home care services, the quality of care provided to recipients of home care services, any appreciable impact on use of nursing facility and inpatient hospital resources, and shall make recommendations regarding the future of home care policy in the state. A final report shall be issued by May 1, 1994 which shall address cost effectiveness, quality of care, and the experience of social service districts in implementing this program, the effectiveness of a provider-based system, and make recommendations relating to management of home care.

§ 82. The commissioner of health, in consultation with the commissioner of social services and the council on home care services, shall establish a program for recruitment of primary care physicians and nurse practitioners to conduct home visits to homebound elderly and disabled persons, who otherwise would require medical transportation to a physician's office, clinic or hospital in order to obtain such physician care. The commissioner of health shall also consult with the medical society of the state of New York, state associations representative of nurse practitioners home care providers and consumers in establishing this program, and shall seek the active involvement of such associations in implementation. Pursuant to such program, the commissioner of social services, upon approval of the state director of the budget, shall provide increased rates of payment under the medical assistance program for physicians who agree to make home visits to such recipients. The commissioner of social services may provide such payments in the form of an enhanced fee paid directly to such physicians or nurse practitioners, or in the form of a discrete fee payable to certified home health agencies, providers of long term home health care programs and providers of personal care services having established written agreements with physicians and nurse practitioners for such enhanced payments for home

visits. Such enhanced fees shall be offset by avoidance of medical transportation costs that would otherwise have been incurred on behalf of a patient.

§ 83. (Intentionally Omitted.)

§ 84. Section 3616 of the public health law is amended by adding a new subdivision 3 to read as follows:

3. Prior to the initial provision of services, and upon the continued provision of services pursuant to each complete reassessment, the agency shall present the recipient or the recipient's representative with a standardized written statement prepared by the department, in consultation with providers of home care services and consumer representatives, which informs the recipient or representative that the services to be provided are subject to change in accordance with a change in the recipient's needs, a change in information about the recipient's needs and/or about the formal and informal services available to meet such needs. The statement shall further inform the recipient or representative that such notification and acknowledgement is for purposes of consumer information and education, and to establish and maintain proper understanding and expectations about the possible course of care to be provided by the agency.

§ 85. Section 369 of the social services law, as added by chapter 256 of the laws of 1966, and the closing paragraph of subdivision 1 as amended by chapter 863 of the laws of 1977, is amended to read as follows:

§ 369. Application of other provisions. 1. All provisions of this chapter not inconsistent with this title shall be applicable to medical assistance for needy persons and the administration thereof by the [public welfare] social services districts.

[Any] 2. (a) Notwithstanding any inconsistent provision of this chapter or other law [notwithstanding], [(a)] no lien may be imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf under this title, except:

pursuant to the judgment of a court on account of benefits incorre[illegible]y paid on behalf of such individual, [and] or

(...) with respect to the real property of an individual who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and who is not reasonably expected to be discharged from the medical institution and to return home, provided, however, any such lien will dissolve upon the individual's discharge from the medical institution and return home; in addition, no such lien may be imposed on the individual's home if one of the following persons is lawfully residing in the home:

(A) the spouse of the individual;

(B) a child of the individual who is under twenty-one years of age or who is blind or permanently and totally disabled; or

(C) a sibling of the individual who has an equity interest in the home and who was residing in the home for a period of at least one year immediately before the date of the individual's admission to the medical institution.

(b) [there shall be] (i) Notwithstanding any inconsistent provision of this chapter or other law, no adjustment or recovery shall be made

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

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against the property of any individual on account of any medical assistance correctly paid to or on behalf of [such] an individual under this title, except:

(A) upon the sale of the property subject to a lien imposed on account of medical assistance paid to an individual described in clause (ii) of paragraph (a) of this subdivision, or from the estate of such individual; or

(B) from the estate of an individual who was sixty-five years of age or older when he or she received such assistance[, and than].

(ii) Any such adjustment or recovery shall be made only after the death of [his] the individual's surviving spouse, if any, and only at a time when [he] the individual has no surviving child who is under twenty-one years of age or is blind or permanently and totally disabled, provided, however, that nothing herein contained shall be construed to prohibit any adjustment or recovery for medical assistance furnished pursuant to subdivision three of section three hundred sixty-six of this chapter.

(iii) In the case of a lien on an individual's home, any such adjustment or recovery shall be made only when:

(A) no sibling of the individual who was residing in the individual's home for a period of at least one year immediately before the date of the individual's admission to a medical institution referred to in subparagraph (ii) of paragraph (a) of subdivision two of this section, and is lawfully residing in such home and has lawfully resided in such home on a continuous basis since the date of the individual's admission to the medical institution, and

(B) no child of the individual who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to a medical institution referred to in subparagraph (ii) of paragraph (a) of subdivision two of this section, and who establishes to the satisfaction of the state that he or she provided care to such individual which permitted such individual to reside at home rather than in an institution, and is lawfully residing in such home and has lawfully resided in such home on a continuous basis since the date of the individual's admission to the medical institution.

(c) Nothing contained in this subdivision shall be construed to alter or affect the right of a social services official to recover the cost of medical assistance provided to an injured person in accordance with the provisions of section one hundred four-b of this chapter.

[2.] (d) Where a recovery or adjustment is made pursuant to this title with respect to a case in a federally-aided category of medical assistance, a part of the net amount resulting from such recovery or adjustment shall be paid or credited to the federal government pursuant to federal law and the regulations of the federal department of [health, education and welfare] health and human services.

3. The department and any social services district is hereby authorized to maintain an action subject to sections one hundred one and one hundred four of this chapter to collect from either a trustee, creator, or creator's spouse any beneficial interest of either the creator or creator's spouse in any trust, other than a testamentary trust, to reimburse such department or district for the costs of medical assistance furnished to, or on behalf of, a creator or creator's spouse. For the purpose of this subdivision, the beneficial interest of the creator or creator's spouse includes the income and any principal amounts to which the creator or creator's spouse would have been entitled by the terms of such trust by right or in the discretion of the

trustee, assuming the full exercise of discretion by the trustee for the distribution of the maximum amount to either the creator or the creator's spouse.

4. Any inconsistent provision of this chapter or other law notwithstanding, all information received by [public welfare] social services and public health officials and service officers concerning applicants for and recipients of medical assistance may be disclosed or used only for purposes directly connected with the administration of medical assistance for needy persons.

§ 86. Section 7-3.1 of the estates, powers and trusts law is amended by adding a new paragraph (c) to read as follows:

(c) A provision in any trust, other than a testamentary trust, which provides directly or indirectly for the suspension, termination or diversion of the principal, income or beneficial interest of either the creator or the creator's spouse in the event that the creator or creator's spouse should apply for medical assistance or require medical, hospital or nursing care or long term custodial, nursing or medical care shall be void as against the public policy of the state of New York, without regard to the irrevocability of the trust or the purpose for which the trust was created.

§ 87. Subdivision 8 of section 1310 of the surrogate's court procedure act is renumbered subdivision 9 and a new subdivision 8 is added to read as follows:

8. It shall be lawful for the debtor to pay a debt which does not exceed five thousand dollars or any part of such debt, under subdivision four of this section, to the department of social services or a social services district where the debt is money payable on account of a deposit with the debtor for the personal needs of the deceased creditor while residing in a medical institution or other facility, or otherwise, and the deceased creditor is indebted to the department or district on account of medical assistance furnished to or on behalf of the deceased creditor.

§ 88. Paragraph (b) of subdivision 3 of section 366-a of the social services law, as added by chapter 256 of the laws of 1966, is amended to read as follows:

(b) notify the applicant in writing of the decision, and where such applicant is found eligible, provide [an] a tamper resistant identification card containing a photo image of the applicant for use in securing medical assistance under this title provided, however, that an identification card need not contain a photo image of a person other than an adult member of an eligible household or a single-person eligible household. The department is not required to provide, but shall seek practical methods for providing, a card with such picture to a person when such person is homebound or is a resident of a residential health care facility, or an in-patient psychiatric facility, or is expected to remain hospitalized for an extended period. The commissioner shall have the authority to define categories of recipients who are not required to have a photo identification card where such card would be limited, unnecessary or impracticable.

§ 89. (Intentionally omitted)

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

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§ 90. Subparagraph 4 of paragraph c of subdivision 5 of section 366 of the social services law, as amended by chapter 165 of the laws of 1991, is amended to read as follows:

(4) Any transfer made by a person or the person's spouse under subparagraph three of this paragraph shall cause the person to be ineligible for nursing facility services, for services at a level of care equivalent to that of nursing facility services for the lesser of (i) a period of thirty months from the date of transfer, or (ii) a period equal to the total uncompensated value of the resources so transferred, divided by the average cost of nursing facility services to a private patient for a given period of time at the time of application as determined by the commissioner. For purposes of this subparagraph the average cost of nursing facility services to a private patient for a given period of time at the time of application shall be presumed to be one hundred twenty percent of the average medical assistance rate of payment as of the first day of January of each year for nursing facilities within the region as established pursuant to paragraph (b) of subdivision sixteen of section twenty-eight hundred seven-c of the public health law wherein the applicant resides.

§ 91. Paragraphs (a) and (b) of subdivision 6 of section 367-a of the social services law are REPEALED and six new paragraphs (a), (b), (d), (e), (f) and (g) are added and paragraph (c), as added by chapter 165 of the laws of 1991, is amended to read as follows:

(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) 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;

(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; and

(v) any other individuals required to be excluded by federal law or regulations.

(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 [copayment] 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.

(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) 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 specified by the department;

(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) In the year commencing April first, nineteen hundred ninety-three and for each year thereafter, 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.

(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.

§ 92. Paragraph (d) of subdivision 7 of section 367-a of the social services law, as added by chapter 165 of the laws of 1991, is amended to read as follows:

(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

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under section 1927 of the federal social security act, 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 being eligible for or in receipt of home relief, 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 [covered outpatient] 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 being eligible for or in receipt of home relief. 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.

§ 93. (Intentionally omitted)

§ 94. (Intentionally omitted)

§ 95. Section 2807-c of the public health law is amended by adding a new subdivision 2-a to read as follows:

2-a. (a) Notwithstanding any inconsistent provision of this section or any other law to the contrary, rates of payment to general hospitals for reimbursement of inpatient hospital services provided to subscribers of health maintenance organizations operating in accordance with the provisions of article forty-four of this chapter or article forty-three of the insurance law for patients discharged on or after July first, nineteen hundred ninety-two, excluding subscribers who are eligible for medical assistance pursuant to the social services law and participants in regional pilot projects established pursuant to chapter seven hundred three of the laws of nineteen hundred eighty-eight, shall be the case based payments per discharge as determined in accordance with subdivision one of this section or the per diem rates of payment determined in accordance with subdivision four of this section or the rate negotiated and approved pursuant to paragraph (b) of subdivision two of this sec-

§ 165. This act shall take effect immediately, provided that:

(a) sections three, fifty-six, ninety-three, ninety-four, ninety-six, ninety-seven, ninety-eight and one hundred fifty-six through one hundred fifty-nine of this act shall take effect April 1, 1992;

(b) sections ten, fourteen, fifteen, thirty-seven, forty-eight, fifty-seven and one hundred two of this act shall be deemed to have been in full force and effect as of January 1, 1991;

(c) section fifty-eight of this act shall be deemed to have been in full force and effect as of March 31, 1992;

(d) section sixty-two of this act shall take effect: (i) insofar as it relates to limits on payments for in-patient services provided to home relief recipients, shall take effect May 1, 1992; (ii) insofar as it relates to other limits on services for home relief recipients, shall take effect July 1, 1992; and (iii) in other respects shall take effect upon promulgation of pertinent regulations but in no event later than July 1, 1993 provided that limitations on inpatient nursing homes services shall not apply to persons who are inpatient nursing home residents on the effective date of this act;

(e) sections sixty-three, sixty-eight through seventy-six, seventy-nine through eighty-two and eighty-nine of this act shall take effect July 1, 1992;

(f) section sixty-six of this act shall take effect September 1, 1992;

(g) section sixty-seven of this act shall take effect May 1, 1992;

(h) section eighty-four of this act shall take effect October 1, 1992;

(i) section eighty-six of this act shall take effect immediately, but shall apply only to trusts created on or after such date;

(j) section eighty-eight of this act shall take effect January 1, 1993;

(k) section ninety-one of this act shall take effect June 1, 1992;

(l) section ninety-two of this act shall apply to determinations of rebate amounts made on and after April 1, 1992;

(m) section one hundred four of this act shall take effect on the first day of the month following thirty days after this act shall have become a law and shall not apply to any arrearages satisfied prior to such date;

(n) section one hundred six of this act shall be deemed to have been in full force and effect as of October 31, 1991;

(o) the commissioner of health is authorized to promulgate on an emergency basis any regulation he or she determines necessary to implement any provision of this act upon its effective date;

(p) the commissioner of social services is authorized to promulgate on an emergency basis any regulation he or she determines necessary to implement any provision of this act upon its effective date, including those provisions relating to determination of client eligibility by social services districts to meet emergency circumstances or prevent eviction and including regulations changing the periods of ineligibility for home relief pursuant to subdivision 5 of section 131 and subdivision 4 of section 341 of the social services law, provided that any such emergency regulation shall be submitted to the legislature upon its promulgation.

(q) the commissioners of health and social services may take any steps necessary to implement this act prior to its effective date;

(r) the provisions hereof shall become effective notwithstanding the failure of the commissioners of health and social services to promulgate regulations implementing this act;

(s) provided, however, that nothing contained herein shall be deemed to affect the application, qualification, expiration or repeal of any provision of law amended by any section of this act and such provisions shall be applied or qualified or shall expire or be deemed repealed in the same manner, to the same extent and on the same date as the case may be as otherwise provided by law except as provided for in sections fifty-four and one hundred sixty-three of this act;

(t) provided, however, that the provisions of section one, three and fifty-six of this act shall expire and be deemed repealed on and after April 1, 1993;

(u) provided, further, that the provisions of subparagraph (i) of paragraph (a) of subdivision 8 of section 365-a of the social services law, as added by section sixty-two of this act shall expire and be deemed repealed on and after July 1, 1994; and the provisions of subparagraph (ii) of paragraph (a) of subdivision 8 of section 365-a of the social services law, as added by section sixty-two of this act shall expire and be deemed repealed on and after December 31, 1993;

(v) provided still further that the provisions of subdivision 12 of section 367-a of the social services law, as added by section sixty-seven of the this act shall expire and be deemed repealed on and after December 31, 1993;

(w) provided that the provisions of section 367-o and 367-n of the social services law, as added by sections seventy-eight and seventy-nine of this act, and section eighty, and eighty-one of this act shall expire and be deemed repealed on and after July 1, 1994;

(x) provided further that the provisions of paragraph (a), (b), (d), (e), (f) and (g) of subdivision 6 of section 367-a of the social services law, as added by, and the amendatory language of paragraph (c) of such subdivision as added by section ninety-one of this act, shall expire and be deemed repealed on and after April 1, 1995 and on such date the provisions of paragraph (c) shall be read as set out immediately preceding the effective date of this act;

(y) and provided further that the provisions of subdivision (f) of section 158 of the social services law as added by section one hundred thirty-five of this act shall expire and be deemed repealed on and after July 1, 1994.

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

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