



STATE OF NEW YORK DEPARTMENT OF HEALTH

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ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 04 OMM/ADM-6

TO: Commissioners of
Social Services

DIVISION: Office of Medicaid
Management

DATE: July 20, 2004

SUBJECT: Resource Documentation Requirements for Medicaid
Applicants/Recipients (Attestation of Resources)

**SUGGESTED
DISTRIBUTION:**

Medicaid Staff
Fair Hearing Staff
Legal Staff
Staff Development Coordinators
Temporary Assistance Directors

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ATTACHMENTS:

See Appendix I for listing of Attachments

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
89 ADM-19 87 ADM-4 80 ADM-19 360-4.8	95 ADM-7	360-2.3 360-4.4 360-4.6(b)	366-a(2) 366-c Ch. 1 of Laws of 2002		

I. PURPOSE

This Administrative Directive (ADM) advises social services districts of the provisions of Chapter 1 of the Laws of 2002 regarding attestation of resources and Medicaid eligibility. Section 51 of Part A of Chapter 1 of the Laws of 2002 eliminated the resource documentation requirement for Medicaid-only applicants/recipients (A/Rs) who are NOT seeking coverage of long-term care services.

II. BACKGROUND

Currently, in determining an individual's financial eligibility for Medicaid, the individual may be required to provide proof of the amount of his/her resources. Pregnant women and infants under the age of one do not have to provide proof of their resources. Children, age one up to the age of nineteen, do not have to provide proof of their resources unless electing to participate in the spenddown program or in instances when SSI-related budgeting is used to establish eligibility. Individuals eligible for Family Health Plus do not have to provide proof of resources. If an individual is seeking Medicaid coverage of nursing facility services, the individual must provide proof of the amount of his/her resources for the past 36 months (60 months for trust-related transfers) in order to ensure that there are no disqualifying resource transfer(s) that would affect the individual's eligibility for such care and services. If an individual does not require Medicaid coverage of nursing facility services, social services districts have had the option of offering a simplified resource review to establish community Medicaid coverage. Under the simplified resource review, the individual is required to provide documentation of current resources only and if otherwise eligible, is entitled to coverage of all Medicaid covered care and services except nursing facility services. This simplified resource review has enabled social services districts to re-deploy staff to other eligibility activities by reducing the number of full resource reviews required.

With the passage of Chapter 1 of the Laws of 2002, Medicaid-only A/Rs who are not seeking coverage of long-term care services will be allowed to attest to the amount of their resources rather than provide proof. This self-attestation of resources will further simplify the documentation requirements for determining eligibility for Medicaid.

Chapter 1 of the Laws of 2002 enacted the new provisions regarding attestation of resources, by adding a new Subdivision 2 to Section 366-a of the Social Services Law (SSL). An amendment to Section 360-2.3 of Title 18 of the New York Codes, Rules and Regulations has been filed on an emergency basis.

III. PROGRAM IMPLICATIONS

Section 366-a(2) of the SSL, as enacted by Chapter 1 of the Laws of 2002, allows self-attestation of resources for certain Medicaid A/Rs. Effective August 23, 2004 retroactive to April 1, 2003, an individual may attest to the amount of his/her resources unless the individual is seeking Medicaid coverage of long-term care services. For purposes of attestation of resources, long-term care services include the following:

1. Nursing Facility Services

- Alternate level of care provided in a hospital
- Hospice in a nursing home
- Nursing home care, except for short-term rehabilitation
- Intermediate care facility
- Home and community-based waiver services
- Managed long-term care in a nursing home

AND

2. Community-Based Long-Term Care Services

- Adult day health care (medical model)
- Limited licensed home care
- Certified home health agency services, except for short-term rehabilitation
- Hospice in the community
- Hospice residence program
- Personal care services
- Personal emergency response services
- Private duty nursing
- Consumer directed personal assistance program
- Assisted living program
- Managed long-term care in the community
- Residential treatment facility
- Home and community-based services waiver programs, including:
 - Long-Term Home Health Care Program
 - Traumatic Brain Injury Waiver Program
 - Care at Home Waiver Program
 - Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program

With the release of this directive social services districts will no longer have the option to offer simplified resource reviews for individuals who are not seeking Medicaid coverage of nursing facility services. Instead, individuals will have the option of applying for:

- 1) Community Coverage Without Long-Term Care - requires a self-attestation to the amount of current resources;
- 2) Community Coverage With Community-Based Long-Term Care - requires proof of current resources; or
- 3) Medicaid coverage of all covered care and services (including nursing facility services)- requires a resource review for the past 36 months (60 months for trusts).

Note: These choices must be offered to all Medicaid-only A/Rs, including **Single Individuals and Childless Couples** (S/CCs). However, since S/CCs are subject to Public Assistance transfer rules, which include a 12-month look-back period and ineligibility for 12 months for a prohibited transfer, in order to determine eligibility for coverages #1 and #2 above, the district must ask at the interview whether the person has made a prohibited transfer within the past 12 months. If the individual states that no transfer has been made and there is no indication of a transfer, eligibility may be determined for the requested coverage. If an S/CC requests Medicaid coverage for all covered care and services (#3 above), resource documentation must be provided for the past 12 months.

Individuals who seek Medicaid coverage for short-term rehabilitation services may attest to the amount of their resources. Short-term rehabilitation services include one commencement/admission in a 12-month period, up to a maximum of 29 consecutive days of each of the following: certified home health care and nursing home care. In the event that the short-term rehabilitation services extend beyond 29 days, the individual will be required to provide proof of his/her resources in order to have Medicaid coverage for the rehabilitation services beyond the 29th day. Proof of resources includes resource documentation for the past 36 months (60 months from trusts) for nursing facility services and current resource documentation for certified home health care. Proof of resources also must be provided in order to have Medicaid coverage for a second commencement/admission of short-term rehabilitation within 12 months from the start of the first commencement/admission.

Medicaid A/Rs have the right to supply proof of their resources at any time. If an individual becomes in need of a service for which he/she does not have coverage, the individual must contact his/her social services district immediately for assistance in obtaining the Medicaid coverage required. Medicaid A/Rs who can reasonably expect to need long-term care services continue to be encouraged to provide proof of their resources in advance of the need for such services. This will help prevent any unnecessary delay in service delivery that may result from the absence of resource documentation. Social services districts may continue to independently verify the accuracy of the information provided by an A/R.

Pregnant women, children under one year of age and children between the ages of one and 19 who have incomes below the applicable federal poverty level are not affected by this change as there continues to be no resource test for these groups. In addition, applicants for the Family Planning Benefit Program, Breast and Cervical Cancer Treatment Program and Family Health Plus Program are not affected by this change since there is no resource test for these programs. Effective with this ADM, otherwise eligible individuals may be enrolled in a managed care plan

without providing proof of their resources, provided the individual is not being enrolled in a managed long-term care plan.

Specified Low Income Medicare Beneficiaries (SLIMBs) and Qualified Medicare Beneficiaries (QMBs) can attest to the amount of their resources for purposes of Medicaid payment of their Medicare Part B premium. There is no resource test for the Qualified Individual Program.

IV. REQUIRED ACTION

A. RESOURCE DOCUMENTATION REQUIREMENTS FOR MEDICAID-ONLY A/Rs

1. Medicaid Applications

Effective August 23, 2004, applicants of any age who are not seeking Medicaid coverage of long term care services may apply using the DOH-4220, "Access New York Application." This application has been revised to require all individuals, other than pregnant women and children under the age of 19, to attest to the dollar amount of their resources. The DOH-4220 may also be used for the Medicaid Buy-In program for Working People with Disabilities (MBI-WPD), provided the individual is not seeking Medicaid coverage of long-term care services. As stated in GIS 04 MA/004, dated February 13, 2004, if the DOH-4220 form is used for the MBI-WPD program, the form must include a notation of the applicant's disabling diagnosis and job title.

If a district receives, or is working on, an older version of the DOH-4220, the district should continue to process the application and determine eligibility. If an applicant attested to having resources below the Medicaid resource limit and fails to submit the requested resource documentation, the application cannot be denied. Such individuals, if otherwise eligible, should be given Community Coverage Without Long-Term Care as discussed in the next section of this directive.

Applicants who want to apply for Medicaid coverage of long-term care services are required to apply using the LDSS-2921, "Application for Public Assistance/Medical Assistance/Food Stamps/Services." For applicants who elect to apply for Medicaid coverage of long-term care services, social services districts must offer the choice of applying for Community Coverage With Community-Based Long-Term Care or Medicaid coverage for all covered care and services including nursing facility services. Districts are encouraged to use the attached "Explanation of the Resource Documentation Requirements for Medicaid," (Attachment I) to discuss these coverage options with applicants.

2. Resource Documentation Requirements

Resource documentation requirements will vary depending on the Medicaid coverage option selected.

a. Community Coverage Without Long-Term Care Services

If an applicant elects to apply for Community Coverage Without Long-Term Care, the applicant may attest to the accumulated amount of his/her resources. An applicant continues to be required to provide documentation of any trust agreement in which the applicant is named as the creator or beneficiary. This will enable the district to evaluate the trust and determine the availability, if any, of the trust income and/or principal. Additionally, if an applicant has an irrevocable pre-need funeral agreement, a copy of the agreement must be provided to the district for purposes of verifying the type of agreement.

Community Coverage Without Long-Term Care includes all Medicaid covered care and services except nursing facility services and community-based long-term care as defined on page 3 of this directive. A new Medicaid Coverage Code 20 defined as "Community Coverage without Long Term Care" is to be used for applicants with no spenddown requirement who attest to the amount of their resources. A new manual and CNS notice entitled, "Notice of Acceptance of Your Medical Assistance Application (Community Coverage Without Long-Term Care)", have been developed to inform individuals who attest to resources of the services for which they will not have coverage. See Section IV.D of the ADM for further information regarding notices.

Social services districts must ask S/CCs whether a prohibited transfer has been made in the past 12 months. If the individual or couple states that no transfer has been made, Community Coverage Without Long-Term Care shall be authorized. If an individual indicates that a transfer has been made, see Section IV.A.2.d of the ADM for further instructions.

(1) Short-term Rehabilitation

Individuals who attest to the amount of their resources will receive Medicaid coverage for short-term rehabilitation services (one commencement/admission in a 12-month period, up to a maximum of 29 consecutive days of each of the following: certified home health care and nursing home care). A recipient or nursing home administrator will need to alert the social services district of an admission to a nursing home in order for the district to make the necessary entries on the Principal Provider Subsystem for payment to the facility. Individuals who are authorized or denied coverage for short-term rehabilitative nursing home care must be sent a notice informing the individual of the decision. The nursing home must also receive a copy of the notice. See Attachment II of this directive for a copy of the notice that must be sent (Authorization for Short-Term Rehabilitative Nursing Home Care).

In the event that the short-term rehabilitation exceeds 29 days, the individual must provide proof of his/her resources in order for Medicaid coverage to be established for the rehabilitative services beyond the 29th day. Proof of resources includes resource documentation for the past 36 months (60 months for trusts) for nursing facility services and current resource documentation for certified home health care.

(2) Change in Need

If a recipient who attested to his/her resources subsequently requests coverage for long-term care services, the date of the request shall be treated as the date of a new application for purposes of establishing the effective date and three-month retroactive period for the increased coverage. Districts must send the recipient a "Long-Term Care Change In Need Resource Checklist" (Attachment III to this directive). Districts may use the cover letter provided in this directive (Attachment IV) to inform the recipient that additional resource information is needed to determine eligibility for long-term care and that unless the recipient returns the information by a specified date, the request for Medicaid coverage for long-term care will be denied. The date of the recipient's request for Medicaid coverage of long-term care services should be clearly documented in the case record. The request date should also be specified on the resource checklist cover letter. Social services districts must complete the appropriate resource review and make an eligibility determination within 45 days of the request.

In cases where a recipient is requesting coverage for nursing facility services (Medicaid coverage for all covered care and services), the look-back period is determined from the date the recipient is requesting coverage to be established for nursing facility services. In instances where the initial days of nursing home care were covered as short-term rehabilitation, the look-back period is determined from the date the recipient started to receive the short-term rehabilitation coverage. For example, a recipient enters a nursing home on August 23, 2004 and receives Medicaid coverage for 29 days of short-term rehabilitation. The individual continues to need nursing home care. The look-back period is the 36-month period immediately preceding August 2004, the month the individual started to receive nursing home care as a short-term rehabilitation service.

If, when reviewing resource documentation, the district also reviews documentation of income, this review may be considered a renewal for purposes of extending the individual's Medicaid authorization/coverage period; otherwise, the case must be renewed as previously scheduled.

In instances where a recipient requests an increase in coverage but does not provide adequate proof of his/her resources, the social services district must either continue current Medicaid coverage or authorize coverage based on the resource information that has been provided. For example:

- i. If a recipient needs Community Coverage With Community-Based Long-Term Care and does not provide documentation of his/her current resources, the social services district must deny the request and continue Medicaid coverage unchanged. The CNS Undercare notice, "Continue MA Unchanged (limited benefit package)," allows the worker to include the reason for the denial of the request for Community Coverage With Community-Based Long-Term Care.
- ii. If a recipient requires Medicaid coverage for all covered care and services, including nursing facility services, and does not provide documentation of his/her resources for the past 36 months (or 60 months for trusts) but does provide documentation of his/her current resources, the social services district must deny the request for Medicaid coverage for all covered care and services and determine eligibility for Community Coverage With Community-Based Long-Term Care. If the recipient fails to provide documentation of his/her current resources, the social services district must deny the request for Medicaid coverage for all covered care and services and continue Medicaid coverage unchanged (Community Coverage Without Long-Term Care). The appropriate CNS Undercare notice allows the worker to include the reason for the denial of Medicaid coverage of all covered care and services when applicable.
- iii. When a social services district determines that an individual in permanent absence status (with or without a community spouse) is not eligible for Medicaid coverage of nursing home care or alternate level of care in a hospital due to the failure or refusal of the individual to provide adequate resource documentation, the A/R's eligibility for Community Coverage With Community-Based Long-Term Care or Community Coverage Without Long-Term Care

must be determined under community budgeting rules, instead of chronic care budgeting. This means that the A/R's countable income is compared to the Medicaid income standard for a one-person household (\$659 effective 2004). This includes institutionalized spouses who are subject to spousal impoverishment budgeting. In such cases, the institutionalized spouse's income is established as if it is the first partial month of institutionalization. If the otherwise eligible institutionalized person's income is at or below the Medicaid income standard for a one-person household, the case must be authorized with the appropriate coverage (Community Coverage With Community-Based Long-Term Care or Community Coverage Without Community-Based Long-Term Care). If the institutionalized person's income exceeds the Medicaid income standard for a one-person household, the case must be authorized as a spenddown with the appropriate coverage (Outpatient Coverage With Community-Based Long-Term Care or Outpatient Coverage Without Long-Term Care).

Medical expenses incurred for nursing home care or alternate level of care in a hospital can be used to meet the individual's spenddown requirement. When an individual incurs medical expenses that meet or exceed his/her monthly spenddown, the individual is eligible for ancillary services not included in the facility's Medicaid rate. New CNS notices for institutionalized persons have been developed to inform individuals of the availability of Medicaid coverage for ancillary services only.

Note: A person with a spouse who does not qualify for Medicaid coverage of a waiver service due to the failure or refusal to provide adequate resource documentation is not entitled to spousal impoverishment budgeting since there is no expectation that the individual will be in receipt of a waiver service for at least 30 days. Regular community budgeting rules apply.

(3) Excess Income/Optional Pay-In Program

Attestors who are eligible for Medicaid subject to a spenddown requirement may participate in the Excess Income/Optional Pay-In Program. As attestors, they are ineligible for coverage of nursing facility services and community-based long-term care services.

If the recipient becomes eligible for outpatient-only services by meeting his/her one-month excess income liability, the recipient will be covered for short-term

rehabilitative certified home health care and nursing home care. In a 12-month period, the recipient may qualify for one commencement/admission, up to a maximum of 29 consecutive days of certified home health care and rehabilitative nursing home care. A new Medicaid Coverage Code 22 "Outpatient Coverage without Long Term Care" has been developed for purposes of this benefit package. Persons who receive short-term rehabilitative nursing home care must have an appropriate entry on the Principal Provider Subsystem to authorize payment to the nursing home. Please note that attestors only need to meet a one-month spenddown requirement for Medicaid payment of nursing home care each month during a period of short-term rehabilitation. Changes have been made to the Principal Provider Subsystem to allow Coverage Code 22 to be entered for a short-term nursing home resident.

Note: Effective with the release of this directive, Coverage Code 02 (Outpatient Only) is only to be used for individuals who provide resource documentation for the past 36 months (60 months for trusts) and who meet a one-month spenddown requirement. Coverage Code 02 will also be an allowable entry on the Principal Provider Subsystem for short-term nursing home stays where the person is not in permanent absence status (not subject to chronic care budgeting).

If an attestor becomes eligible for both outpatient and inpatient medical care by meeting his/her six-month excess income liability, the recipient will also be covered for short-term rehabilitative care. Such individuals are to be given Medicaid Coverage Code 20 "Community Coverage without Long Term Care".

Worker selected messages have been added to CNS spenddown notices to inform individuals who attest to resources of the services for which they will not have Medicaid coverage.

(4) Collateral Investigations

Social services districts may continue to verify the accuracy of the resource information provided by an A/R through collateral investigations. If there is an inconsistency between the information reported by the A/R and information obtained by the district, and the information obtained by the district is current, the district shall re-determine the recipient's eligibility based on the new information obtained through its investigation. If an individual is determined to be eligible for the Family Health Plus Program, Family Health Plus coverage should be authorized. If an individual is not eligible for Family Health Plus and/or the district requires further information about a particular resource in order to make an eligibility decision, the recipient must be notified to provide the necessary information. The district should request only

documentation that is necessary and relevant to the investigation. If the recipient fails or refuses to provide the requested information, Medicaid coverage shall be discontinued on the basis of the recipient's failure or refusal to provide information necessary to establish eligibility.

(5) Managed Care Implications

Recipients with Community Coverage Without Long-Term Care (Coverage Code 20) will be eligible to enroll in managed care, with the exception of managed long-term care. Once enrolled, the enrollee will be eligible for all care and services covered under the plan as well as any wraparound services that are covered under Medicaid fee-for-service. This includes the nursing home and home care benefits as defined in the benefit package of the managed care contract.

Upon disenrollment from managed care, such individuals' eligibility for Medicaid coverage of long-term care services will depend on whether the individual provided documentation of his/her resources.

b. Community Coverage With Community-Based Long-Term Care

Individuals electing to apply for Community Coverage With Community-Based Long-Term Care must provide documentation of current resources. Community Coverage With Community-Based Long-Term Care includes all Medicaid covered care and services except nursing facility services as defined on page 3 of this directive. The coverage does, however, include short-term rehabilitative nursing home care. A new Medicaid Coverage Code 19 defined as "Community Coverage with Community Based Long Term Care" has been developed for this benefit package. Coverage Code 19 is to be used for applicants/recipients with no spenddown requirement and those who meet a six-month excess income liability. See Section IV.D of the ADM for information regarding notices.

Individuals who meet a one-month excess income liability are to be given Coverage Code 21 (Outpatient Coverage with Community Based Long Term Care). Coverage Code 21 will cover all outpatient services except home and community-based waiver services. Coverage Code 21 will also include short-term rehabilitative nursing home care.

An otherwise eligible individual who fails or refuses to provide adequate resource documentation shall be denied Community Coverage With Community-Based Long-Term Care. Such individual shall be authorized with coverage for Community Coverage Without Long-Term Care if adequate information (not

documentation) regarding the individual's resources is provided.

If an S/CC indicates that no transfer has been made in the past 12 months, Community Coverage With Community-Based Long-Term Care shall be authorized. See Section IV.A.2.d of the ADM for further instructions if an S/CC indicates that a transfer has been made.

(1) Short-term Rehabilitative Nursing Home Care

Individuals who are eligible for Community Coverage With Community-Based Long-Term Care are eligible for certified home health care whether on a short-term or long-term basis. Individuals who have Community Coverage With Community-Based Long-Term Care are also eligible for one admission in a 12-month period of up to a maximum of 29 consecutive days of short-term rehabilitative nursing home care. Effective with the release of this directive, Coverage Codes 19 and 21 are an allowable entry on the Principal Provider Subsystem for short-term rehabilitative nursing home care.

(2) Change in Need

If a recipient who has documented current resources becomes in need of nursing facility services, the district must inform the recipient of the additional resource documentation that must be provided in order to determine eligibility for nursing facility services. Should a recipient fail or refuse to provide the requested resource documentation, the district shall deny Medicaid coverage for nursing facility services. In cases where the individual (with or without a community spouse) is in permanent absence status in a nursing home or on alternate level of care status in a hospital, the recipient's ongoing eligibility for Community Coverage With Community-Based Long-Term Care shall be determined under the community budgeting rules outlined in Section IV.A.2.a(2)(iii) of this directive.

Note: An individual who does not qualify for Medicaid coverage of a waiver service due to the failure or refusal to provide adequate resource documentation is not entitled to spousal impoverishment budgeting since there is no expectation that the individual will be in receipt of a waiver service for at least 30 days. Regular community budgeting rules apply.

(3) Managed Care Implications

Recipients with Community Coverage with Community-Based Long-Term Care (Coverage Code 19) will be eligible to enroll in managed care. Once enrolled, the enrollee will be eligible for all care and services covered under the plan as well as any wraparound services that are covered under Medicaid fee-for-service. This includes the nursing home and home care benefits as defined in the benefit package of the managed care contract.

Upon disenrollment from managed care, such individuals' eligibility for Medicaid coverage of long-term care services will depend on whether the individual provided documentation of his/her resources.

c. Medicaid Coverage for All Covered Care and Services

If an individual elects to apply for all Medicaid covered care and services, the social services district must follow current documentation requirements. To be eligible for all covered care and services (Coverage Code 01-Full Coverage), the applicant must provide documentation of his/her resources for the past 36-month period (or 60 months for trusts) immediately preceding the date the individual requests Medicaid coverage. Single Individuals and Childless Couples must provide resource documentation for the past 12 months.

Effective with the release of this directive, individuals who meet a monthly spenddown requirement are to be given Outpatient Only Coverage (Coverage Code 02) only if resource documentation has been provided for the past 36 months (60 months for trusts). Coverage Code 02 includes Medicaid coverage of home and community-based waiver services and with the release of this directive, temporary stays in a nursing home.

If an A/R who needs nursing facility services does not provide documentation of his/her resources for the past 36 months (60 months for trusts/12 months for SCCs) but does provide current resource documentation, the social services district must determine Medicaid eligibility for Community Coverage With Community-Based Long-Term Care. If the A/R provides information on the amount of his/her current resources but does not provide supporting documentation, the district must determine Medicaid eligibility for Community Coverage Without Long-Term Care. For individuals in permanent absence status in a nursing home or on alternate level of care status in a hospital, the individual's eligibility must be determined using the community budgeting rules outlined in Section IV.A.2.a(2)(iii) of this directive.

Note: An individual who does not qualify for Medicaid coverage of a waiver service due to the failure or refusal to provide adequate resource documentation is not entitled to spousal impoverishment budgeting since there is no expectation that the individual will be in receipt of a waiver service for at least 30 days. Regular community budgeting rules apply.

d. Transfer of Assets

For individuals who are determined to have made a prohibited transfer of assets, Coverage Code 10 (Limited Coverage) will continue to be used to limit Medicaid covered care and services to all Medicaid covered care and services except nursing facility services. An S/CC individual or couple is ineligible for Medicaid for a period of 12 months for a transfer of a non-exempt resource for the purpose of qualifying for Medicaid. The 12-month period of ineligibility begins with the month of transfer.

For individuals who meet a spenddown requirement who are found to have made a prohibited transfer of assets, a new Medicaid Coverage Code 23 (Outpatient Coverage with no Nursing Facility Services) must be used when the individual meets his or her one-month spenddown liability. Coverage Code 23 will prohibit payment of home and community-based waiver services and short-term rehabilitative nursing home care.

If an individual states that a transfer has been made but does not provide documentation of the transfer, one of the following coverage codes must be assigned based on the documentation that has been provided:

- Coverage Code 19 "Community Coverage with Community Based Long Term Care" for current resource documentation
- Coverage Code 20 "Community Coverage without Long Term Care" for attestation
- Coverage Code 21 "Outpatient Coverage with Community Based Long Term Care" for current resource documentation and a spenddown requirement
- Coverage Code 22 "Outpatient Coverage without Long Term Care" for attestation and a spenddown requirement

These individuals are not entitled to short-term rehabilitative nursing home care.

If an S/CC individual or couple states that a transfer has been made but does not provide documentation of the transfer, Medicaid coverage shall be denied.

3. Medicaid Renewals

For renewals (non-chronic care) mailed on or after August 23, 2004, Medicaid-only recipients who are subject to a resource test will be instructed to itemize their resources and send in documentation if they are receiving Medicaid coverage for long-term care services. If a recipient provides the value of his/her resources, but fails to provide adequate resource documentation, the social services district must determine the recipient's ongoing eligibility for Community Coverage Without Long-Term Care. Social services districts must provide adequate and timely notice if there is a reduction in a recipient's Medicaid coverage.

Recipients who are not receiving Medicaid coverage of long-term care services will be asked to itemize their current resources and attest to the value of the resources.

When renewing Medicaid coverage for a recipient in chronic care status, social services districts shall continue to use the LDSS-4411 "Recertification for Medical Assistance (Chronic Care)".

B. RECIPIENTS WHO LOSE ELIGIBILITY FOR SUPPLEMENTAL SECURITY INCOME

In accordance with 80 ADM-19, individuals who lose Supplemental Security Income (SSI) eligibility continue to remain eligible for Medicaid coverage of all covered care and services until a separate determination of eligibility is made. If the individual is determined eligible based on information on the State Data Exchange (SDX), social services districts must authorize Medicaid coverage for all covered care and services for up to one year. If eligibility cannot be determined due to insufficient information, social services districts must continue Medicaid coverage for all covered care and services and notify the individual to provide the additional information within 30 days. Unless the individual's SSI was discontinued due to a prohibited transfer, the individual is not required to provide documentation of his or her resources for purposes of the ex-parte eligibility determination. Provided the individual is otherwise eligible, the individual shall continue to qualify for Medicaid coverage of all covered care and services or, if eligible with a spenddown requirement, outpatient only coverage, until the first scheduled Medicaid renewal.

C. APPLICATIONS/RENEWALS FOR TEMPORARY ASSISTANCE AND MEDICAID

Effective August 23, 2004, when an applicant for both Temporary Assistance (TA) and Medicaid provides information concerning his or her resources but fails to provide the requested proof, the request for TA may be denied but a separate Medicaid eligibility determination must be made for Community Coverage Without Long-Term Care or Family Health Plus. The individual's notice of this Medicaid determination will inform the individual of the care and services for which he or she does not have coverage and the reason for the decision.

Individuals who are closed on Temporary Assistance for failure to document resources are also to be referred to Medicaid for a separate eligibility determination. Temporary Assistance closing reason code V20 "Failure to Provide Verification (Closing or Recert Closing)" should be used to generate the appropriate Medicaid extension.

D. NOTICES

1. CNS

Upstate, new CNS acceptance notices have been developed to inform individuals of the action taken on the Medicaid application. This includes informing individuals who have a resource test of the care and services for which there is no eligibility based on the resource documentation provided. Numerous changes have been made to upstate CNS undercare notices to accommodate the new policies contained in this directive. Details regarding CNS changes are contained in the August 2004 WMS/CNS Coordinator Letter associated with this migration. The WMS and CNS Code Cards will also be updated to reflect any new codes.

2. Manual

a. LDSS-3622 (Rev. 3/03): Notice of Decision on Your Medical Assistance Application

The LDSS-3622 may be used to inform an applicant that his/her Medicaid application has been accepted for all covered care and services, denied or no action taken. When using the acceptance portion of the notice, the notice must only be used for:

- pregnant women and children who are eligible for full Medicaid coverage; and
- Medicaid-only applicants who provided resource documentation for the past 36-months (60 months for trusts) and who are eligible for full Medicaid coverage including nursing facility services.

Administrative Directive 95 ADM-7 "Community Coverage Option" is cancelled with the release of this ADM. The mandated notices contained in a 95 ADM-7 have been either deleted or revised. The revised notices are contained in this directive. To ensure that usage of the new and revised notices begins immediately, districts are instructed to reproduce the attached copies until the notices are available.

b. Notice of Acceptance of Your Medical Assistance Application (Community Coverage Without Long-Term Care) (Rev. 6/04) (Attachment V)

This notice may be used to inform an applicant that his/her Medicaid application has been accepted for care and services except nursing facility services and community-based long-term care, with or without a spenddown requirement. The notice

advises the individual that he/she is not eligible for nursing facility services or community-based long-term care and the actions to be taken in the event coverage is needed for these services or for short-term rehabilitation services. The notice must be used for:

- applicants who attest to the amount of their resources;
- applicants who request community coverage for community-based long-term care but do not provide documentation of current resources; and
- applicants who request Medicaid coverage for all covered care and services but do not provide documentation of resources for the past 36 months (or 60 months for trusts) including current resource documentation.

For individuals who request Medicaid coverage for nursing facility services or community-based long-term care but do not provide adequate resource documentation, the worker must list the resource documentation that was not provided. If Medicaid coverage is authorized with a spenddown requirement, the box "Excess Income/Resources" must be checked and the LDSS-3973, "Notice of Decision on Your Medical Assistance Application (Excess Income/Resources)" must be completed.

Note: When completing an LDSS-3973 for an institutionalized spouse who has a community spouse (institutionalized spouse is expected to need nursing facility services for at least 30 consecutive days), the total monthly deduction amount must include any contribution to the community spouse. The allowable income standard is the Medicaid income level for a household of one since the institutionalized spouse is budgeted as if it is the first or partial month of institutionalization.

c. LDSS-4489 (Rev. 6/04): Notice of Acceptance of Your Medical Assistance Application (Community Coverage With Community-Based Long-Term Care) (Attachment VI)

The LDSS-4489 may be used to inform an applicant that his/her Medicaid application has been accepted for community coverage with community-based long-term care, with or without a spenddown requirement. The notice advises the individual that he/she is not eligible for nursing facility services and the actions to be taken in the event coverage is needed for nursing facility services or short-term rehabilitation. The notice must be used for:

- applicants who provide current resource documentation and are eligible for Medicaid coverage for community-based long-term care with or without a spenddown requirement; and
- applicants who request Medicaid coverage for all covered care and services but only provide current resource documentation.

For individuals who request Medicaid coverage for nursing facility services but do not provide adequate resource documentation, the worker must list the documentation that was

not provided. If Medicaid coverage is authorized with a spenddown requirement, the box "Excess Income/Resources)" must be checked and the LDSS-3973, "Notice of Decision on Your Medical Assistance Application (Excess Income/Resources)" must be completed. In addition, the "Note" in "b" above would apply to an institutionalized spouse who requests coverage for nursing facility services, is expected to receive such services for at least 30 consecutive days, but does not provide adequate resource documentation for the past 36 months (60 months for trusts).

- d. LDSS-4038 (Rev. 6/04): Explanation of the Excess Income Program (Attachment VII)
The revised "Explanation of the Excess Income Program" must be used with the LDSS-3973, "Notice of Decision on Your Medical Assistance Application Excess Income/Resources." The informational notice has been revised to include information about resource documentation requirements for long-term care services
- e. LDSS-4548 (Rev. 4/04): Optional Pay-In Program for Individuals with Excess Income (Attachment VIII)
The revised Optional Pay-In Program for Individuals with Excess Income" must be used with the LDSS-3973, "Notice of Decision on Your Medical Assistance Application (Excess Income/Resources)." The informational notice has been revised to include information about resource documentation requirements for long-term care services and the requirements for coverage of short-term rehabilitation.
- f. Authorization for Short-Term Rehabilitative Nursing Home Care (Rev. 4/04) (Attachment II)
This notice is to be used to accept or deny an individual's request for Medicaid coverage of short-term rehabilitative nursing home care. A copy of the notice must be sent to the facility when authorizing coverage. When applicable, the notice will include information concerning any income that must be contributed toward the cost of care.

Note: See Section V.C. (Managed Care/Managed Long-Term Care) for additional manual managed care notice information.

V. SYSTEMS IMPLICATIONS

Systems codes and edits have been modified to support attestation of resources. A detailed description of the items below can be found in the August 2004 WMS/CNS Coordinator Letter. The following is a summary of the changes.

A. UPSTATE WMS IMPLICATIONS

In order to systemically support attestation of resources, a new single character field, entitled "Resource Verification Indicator" (RVI is the field label), has been added to "WKUM01" and will be displayed on the LDSS 3209. An entry in this field will be required on MA Only cases (CT 20) for Opening (02), Re-Opening (10) and Recertification (06)

transactions as well as Undercare Maintenance Transactions (05) where the Case Type is being changed from 22 (MA-SSI) or 24 (FHP) to 20. An RVI will be required to be worker entered UNLESS all case members belong to one of the following categories:

- Pregnant Women (Categorical Codes 15, 42, 43, 48, 58, 59)
- Expanded Eligibility for Children and LIF Eligible Children (Categorical Codes 44, 45, 46, 47, 51, 60, 01-09)
- Unborns
- Family Planning Benefits Program (Categorical Codes 68 and 69)
- Breast and Cervical Cancer Treatment Program (Categorical Code 61, 62 or 63)

If an individual on a case has a Categorical Code which is other than one of those listed above, the RVI value entered on WKUM01 must be equal to "1", "2", "3" or "4". If all case members have one of the Categorical Codes listed above, the system will generate an RVI value of "9" if left blank or the worker will be able to enter a "9".

The RVI values are defined as follows:

- "1" (Resources verified for 36 months) - A value of "1" is to be used for cases in which an applying household member has a resource test, resource documentation has been provided for the past 36 months (60 months for trusts) and there is no transfer of assets penalty. This value is to be used for cases with or without a spenddown of income requirement.
- "2" (Resources verified only for current month) - For cases in which an applying household member has a resource test and documentation of current resources has been provided, the value "2" should be used. This value will provide coverage for community-based long-term care services and is to be used for cases with or without a spenddown of income requirement.
- "3" (Resources not verified) - The value "3" is to be used for cases in which an applying household member has a resource test and has elected to attest to the amount of his/her resources. This value will prohibit coverage for long-term care services and is to be used for cases with or without a spenddown of income requirement.
- "4" (Transfer of resources) - For those cases in which a district has determined that an individual has made a prohibited transfer and is not eligible for nursing facility services, the value "4" must be entered. This value will prohibit coverage of nursing facility services and will identify cases in which an actual transfer of assets has been made. The value "4" is to be used for cases with or without a spenddown of income requirement.
- "9" (Exempt from resource verification) - A value of "9" will be required if all individuals on the case are one of the following: pregnant women, unborn, expanded child eligible under the federal poverty level, post-partum mother, participant in the Breast and Cervical Cancer Treatment Program

or a participant in the Family Planning Benefit Program. This value will provide coverage for all Medicaid covered care and services, unless otherwise restricted based on income or program participation.

For mixed households where there are household members who have no resource test, and members who have a resource test, the RVI value should be selected for the household members who have a resource test. The Categorical Code and eligibility outcome for the other family members will help the worker determine the correct Coverage Code to be data entered.

Note: Upstate, when a Case Type 20 is opened for a Case Type 22 closing based on the Auto-SDX, the system will store an RVI of "1".

Conversion of Active Cases - The weekend of the migration, the system will generate and store a value in the RVI field for all active Medicaid cases (Case Type 20) using the following logic:

- a. If all individuals in the case are exempt from resource verification, as explained above, the RVI value will be set to "9".
- b. If no one in the case has a Coverage Code of 10, the RVI value will be "1".
- c. If at least one individual has a Coverage Code of 10, the RVI value will be "4".

New Medicaid Coverage Codes - Effective with this implementation, the following new Coverage Codes will be added:

Coverage Code 19 (Community Coverage with Community Based Long Term Care)

Coverage Code 20 (Community Coverage without Long Term Care)

Coverage Code 21 (Outpatient Coverage with Community Based Long Term Care)

Coverage Code 22 (Outpatient Coverage without Long Term Care)

Coverage Code 23 (Outpatient Coverage with no Nursing Facility Services)

Coverage Code 24 (Community Coverage without Long Term Care (legal alien during 5 year ban - NYC only)

The Principal Provider and Restriction/Exception subsystems and the Downgrade Matrix have been revised to accommodate the new Coverage Codes. Detailed information regarding these changes can be found in the August 2004 WMS/CNS Coordinator Letter.

MBL Implications

MBL Resource Code "98" defined as "Other Liquid Resources" should be used to identify an attestor's total countable resource amount. If the type of resource has been identified, the appropriate MBL Resource Type code should be used.

B. NYC WMS IMPLICATIONS

NYC WMS instructions will be provided under separate cover.

C. MANAGED CARE/MANAGED LONG-TERM CARE

Individuals with Coverage Codes 19, 20 or 24 (NYC only) can be enrolled in the regular Managed Care program. Individuals with Coverage Codes 19, 21 or 23 can be enrolled in Managed Long-term Care. It should be noted that if a managed long-term care participant requires nursing facility services, a determination of on-going eligibility is required. If an individual had previously not provided documentation of his/her resources for the past 36 months (60 months for trusts), such documentation must be provided as a condition of on-going eligibility.

Note: Coverage Code 19 will be accepted as a PCP enrollment for managed long-term care. For individuals with Coverage Code 21 or 23, the coverage code must first be changed to 19 or 01 coverage in order for a PCP enrollment to be accepted.

Upon disenrollment, the RVI field, State/Federal Charge Code and/or Categorical Code will be referenced in order to change to the appropriate Coverage Code. Timely and adequate notice is required for any decrease in coverage following disenrollment. Appropriate manual managed care disenrollment notice must be sent in addition to the eligibility notice. For purposes of timely and adequate notice, all of the new Coverage Codes are considered to be a decrease in coverage from managed care coverage.

For persons being disenrolled from managed care due to permanent placement in a medical facility, chronic care budgeting and the establishment of a contribution toward cost of care is effective the month following the month in which the person's status changed to permanent absence status.

Note: For individuals who are disenrolled from managed long-term care, the system is not able to distinguish individuals with a spenddown requirement from individuals with no spenddown requirement. As a result, the cases are given either Coverage Code 01, 10 or 19 based on edits. Managed long-term care cases should be reviewed upon disenrollment for possible correction. Cases that require a change to a spenddown requirement must be given timely and adequate notice before the effective date of the change.

D. EEDSS

EEDSS will be revised to comply with the provisions of this directive.

VI. EFFECTIVE DATE

The provisions of this directive are effective for all actions taken on a case or application on or after August 23, 2004. However, the provisions cannot be applied to any period prior to April 1, 2003.

Kathryn Kuhmerker, Deputy Commissioner
Office of Medicaid Management