



# STATE OF NEW YORK DEPARTMENT OF HEALTH

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**ADMINISTRATIVE DIRECTIVE**

**TRANSMITTAL:** 10 OHIP/ADM-1

**TO:** Commissioners of  
Social Services

**DIVISION:** Office of Health  
Insurance Programs

**DATE:** January 11, 2010

**SUBJECT:** Elimination of the Resource Test for Non-SSI-Related  
Medicaid/Family Health Plus Applicants/Recipients

<b>SUGGESTED DISTRIBUTION:</b>	Medicaid Staff Temporary Assistance Directors Staff Development Coordinators Fair Hearing Staff
<b>CONTACT PERSON:</b>	Local District Liaison: Upstate: (518)474-8887 New York City: (212)417-4500
<b>ATTACHMENTS:</b>	None

**FILING REFERENCES**

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
08 OHIP/ADM-4 05 OMM/INF-2 04 OMM/ADM-6			Chapter 58 of the Laws of 2009, Sections 58-59(d), SSL 366 and 369-ee		GIS 09 MA/027 GIS 08 MA/022

**I. PURPOSE**

The purpose of this Administrative Directive is to advise local social services districts of the provisions of Chapter 58 of the Laws of 2009, which eliminate the resource test for Family Health Plus (FHPlus) applicants/recipients (A/Rs), and for Medicaid A/Rs who are not aged (age 65 or over), certified blind, or certified disabled.

**II. BACKGROUND**

Currently, certain eligibility groups such as pregnant women, infants under the age of one, and children ages one to 19 who are eligible at expanded income levels, do not have a resource test. In addition, there is no resource test for applicants for the Family Planning Benefit Program, Medicaid Cancer Treatment Program, AIDS Health Insurance Program (AHIP) and the Medicare Savings Program (Qualified Medicare Beneficiaries (QMBs), Specified Low Income Medicare Beneficiaries (SLIMBs), and Qualified Individuals (QIs)). Policyholders who have utilized the minimum required benefits under a total asset Partnership for Long-Term Care insurance policy are also not subject to a resource test. For other Medicaid categories and FHPlus, A/Rs must have resources at or below the Medicaid resource level in order to qualify for coverage.

To simplify the eligibility rules for many A/Rs and local district workers, Sections 58 through 59(d) of Chapter 58 of the Laws of 2009 amended Sections 366 and 369-ee of the Social Services Law to eliminate the resource test for FHPlus and all Medicaid categories except for the SSI-Related eligibility group.

For SSI-Related Medicaid A/Rs who are determined eligible for Medicaid under the SSI-Related budgeting methodology, there continues to be a resource test. The resource documentation requirements outlined in 04 OMM/ADM-6, "Resource Documentation Requirements for Medicaid", continue to apply to SSI-Related A/Rs. If a certified blind or certified disabled applicant, who does not have Medicare or equivalent insurance, is not otherwise eligible for Medicaid, but qualifies for FHPlus, there will be no resource test in determining FHPlus eligibility.

**III. PROGRAM IMPLICATIONS**

Effective for eligibility periods beginning on or after January 1, 2010, FHPlus and non-SSI-Related Medicaid A/Rs will not have resources considered in determining eligibility. This change includes the following Medicaid categories: Single/Childless Couples (S/CC), Low Income Families (LIF), ADC-Related (including adults who spend down excess income to the Medicaid income level), children under 21 years of age when comparing income to the Medicaid income level (Under 21), and parents living with their dependent child (ren) under age 21 with income at or below the Medicaid income level (FNP Parents).

Previously, when determining eligibility for these Medicaid categories, available and countable resources were compared to the applicable Medicaid resource level. If resources exceeded that level, the A/R was ineligible for Medicaid due to excess resources. The Medicaid resource level was also used to determine FHPlus eligibility.

The elimination of the resource test for FHPlus and Medicaid non-SSI-Related A/Rs aligns the treatment of resources for parents and families with the treatment of resources for children at expanded income levels. This change will also simplify the eligibility determinations for these groups, as different categorical rules used to determine countable and exempt resources will no longer be applied, because resources will no longer be considered.

Resource requirements continue to apply to SSI-Related Medicaid A/Rs whose eligibility is determined using the SSI-Related budgeting methodology, unless they are applying for Medicare Savings Program (MSP)-only. Qualified Disabled and Working Individuals (QDWIs) and applicants for the Medicaid Buy-In for Working People with Disabilities (MBI-WPD) will continue to have a resource test. Eligibility for COBRA Continuation Coverage also continues to require a resource test, regardless of the individual's category, because the SSI-Related budgeting methodology is used to determine COBRA Continuation Coverage eligibility. SSI-Related Medicaid A/Rs, including MBI-WPD A/Rs, who are not seeking coverage of long-term care services, will continue to be allowed to attest to the amount of their resources rather than provide proof. If an SSI-Related/MBI-WPD A/R is seeking Medicaid coverage of community-based long-term care services, the A/R must provide documentation of current resources only, and if otherwise eligible, is entitled to coverage of all Medicaid covered care and services, except for nursing facility services.

An SSI-Related A/R who also meets the ADC-Related categorical requirements has a choice between ADC-Related budgeting or SSI-Related budgeting. In determining eligibility under ADC-Related budgeting, there is no resource test.

**IV. REQUIRED ACTION**

**A. Resource Requirements for Medicaid-Only A/Rs**

**1. Applications/Renewals**

Effective for budget periods beginning on or after January 1, 2010, FHPlus and Medicaid for non-SSI-Related A/Rs must not be denied or discontinued due to resources. This includes failure to provide resource information. Currently, the DOH-4220, "Access NY Health Care" application, and the Medicaid/FHPlus renewal ask for the dollar amount(s) of resources. If an A/R fails to complete the resource question(s) on the application/renewal, the A/R cannot be denied initial or ongoing coverage. The DOH-4220 and Medicaid/FHPlus renewal will be revised to remove resource questions for non-SSI-Related A/Rs.

If an A/R requests coverage in the 3-month retroactive period, there is a resource test for the month(s) prior to January 1, 2010. If a district receives an application on or after January 1, 2010, that results in a denial due to excess resources for the month(s) prior to January 1, 2010, but an acceptance as of January 1, 2010, due to the elimination of the resource test, two manual notices must be sent. One notice will advise the applicant of the decision to deny the application for the month(s) in the retroactive period prior to January 1, 2010, due to excess resources, and a second notice will advise of the acceptance of the application and the effective date.

Districts must not request resource information and/or documentation when processing applications or renewals for FHPlus or non-SSI-Related Medicaid A/Rs with an effective date on or after January 1, 2010, except for households in which there are both SSI-Related and non-SSI-Related A/Rs (mixed households). SSI-Related A/Rs, including MBI-WPD A/Rs, must attest to or document the amount of their resources, depending on the type of coverage requested by the A/R. The policies and procedures contained in 04 OMM/ADM-6 continue to apply to SSI-Related Medicaid A/Rs. Medicare QDWIs and COBRA Continuation Coverage applicants can continue to attest to the amount of their current resources.

Although there is no resource test for non-SSI-Related and FHPlus A/Rs, districts should continue to review the Resource File Integration (RFI) reports. However, districts are encouraged to minimize the scope of investigation into resources of the non-SSI-Related or FHPlus A/R to those that are related to current income. Any action associated with the income verification should be maintained in the case record and/or appended to the applicable RFI report. RFI reports must be resolved using the appropriate resolution code.

**Note:** Further instructions regarding resource information as a means to determine maintenance will be issued under separate cover.

## **2. Resource Verification Indicator and Coverage Code**

As advised in 04 OMM/ADM-6, a Resource Verification Indicator (RVI) is a one character field for Medicaid-only cases (Case Type 20) which was added to the Welfare Management System (WMS) in 2004, to support attestation of resources. The RVI value in conjunction with the case member's Categorical Code and eligibility outcome help determine the correct coverage for the case member. The RVI is selected based on the resource documentation provided for anyone on the case who has a resource test. If no applying case members have a resource test, an RVI of 9 (Exempt from resource verification) is assigned (in New York City it is system

generated). Medicaid-only cases that have an RVI value of 9 receive Coverage Code 01 (Full coverage), or 02 (Outpatient only) if eligible with a spenddown, and the spenddown requirement has been met.

Similar to pregnant women and children eligible at expanded income levels who have no resource test, non-SSI-Related Medicaid A/Rs must be given an RVI value of 9 (in New York City it is system generated) with Coverage Code 01 or 02 (worker entered in NYC). See Section V of this directive for further information regarding systems support for RVI 9.

For mixed households where there are household members who have no 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.

**3. Eligibility Under a Different Category**

An SSI-Related individual who also meets the ADC-Related categorical requirements has a choice between ADC-Related budgeting or SSI-Related budgeting. If the individual's income eligibility is the same under both budget types and the individual is not eligible for, or does not wish to participate in MBI-WPD, the individual must be given the ADC-Related category of assistance, since benefits under this category are not limited based on resources. An SSI-Related individual cannot have eligibility determined under the S/CC category of assistance. This rescinds instructions previously provided in GIS 08 MA/022, which allowed SSI-Related A/Rs to use an S/CC budget, if more advantageous.

If an individual is 65 years of age or older, but is otherwise categorically eligible as ADC-Related, s/he may be categorized as ADC-Related, if that is more advantageous to the individual.

A certified blind or certified disabled individual who documents or attests to resources in excess of the Medicaid resource level must have eligibility considered for FHPlus. Resources are not considered in the eligibility determination for FHPlus.

**B. Medicaid Renewals on or After January 4, 2010 for Budgets Effective January 1, 2010**

For Budget Types 01 (LIF/ADC-Related) and 02 (S/CC), MBL will not allow entry of resources. Additionally, budgets with Expanded Eligibility Codes of B (Federal Poverty Level Children), F (FHPlus for Families/19 - 20 Living with Parents), N (FHPlus for 19 - 20 Not Living with Parents) and S (FHPlus for Single/Childless Couples) will also not allow entry of resource information.

For Budget Types 05 (SSI-Related and LIF/ADC-Related) and 06 (SSI-Related and S/CC), resources must be entered but MBL will not calculate or display resources for the non-SSI-Related portion of the combined budget, nor will it calculate resources for a Medicare Savings Program-only A/R. Also, for Budget Types 09 (Chronic Care and LIF/ADC-Related) and 10 (Chronic Care and S/CC), resources must be entered but MBL will not calculate or display resources for the non-SSI-Related portion of the combined budget.

**C. Client Notices System**

**1. Upstate**

CNS changes will be made with the February 2010 migration. Until that time, local district workers should not use resource related CNS codes or messages for FHPlus or non-SSI-Related Medicaid A/Rs that refer to Medicaid or Family Health Plus ineligibility due to resources. These reason codes are:

**Acceptance Reason Codes**

S57, S59, S60, S61, S66, S67, S80, S58

**Discontinuance Reason Codes**

V94, U57, U58, U91, X48, X15, X17, U33

**Denial Reason Codes**

X50, U73, U35, U34, X45, X46, X47, U49, U62, U64, S88, U74, U63, X44

**Undercare Reason Codes**

V79, V77, V78, V93, V95, S25, S20/BG, S20/BE, S20/CG, S20/CE

In many instances, notices will be changed to prevent inappropriate language from being generated, e.g., all S/CC notices and FHPlus notices have resource language deleted as appropriate. However, there are numerous notices that can be used for either a non-SSI-Related individual or an SSI-Related individual, and, therefore, the resource language in these notices could not be deleted. For resource related messages in affected notices, message selection has been revised to include the notation "SSI-Related only". This notation is for the clarification of the worker and will not be included in the notice sent to the A/R.

Also, certain existing notices will have title changes to reflect that they should now be used only for SSI-Related individuals. Further details will be provided in the WMS/CNS Coordinator Letter that will be issued in conjunction with the February migration.

References to resources will be removed from renewals that are generated after the February 16, 2010 migration for RVI 9 cases. Districts should be aware that renewals returned for several months after the February migration date will still include reference to resource information, depending on how far in advance a district schedules renewals to be sent. FHPlus and non-SSI-Related recipients must not have their coverage discontinued for either failure to complete the resource questions or for excess resources.

**2. New York City**

CNS changes will be made with the February 2010 migration. The following codes will be revised:

**Case Level Discontinuance Reason Codes**

E24, E26, E27, E49, F32, F55

**Line Level Denial/Discontinuance Reason Codes**

F32, F55

**Recertification Budget Notice Codes**

B02, B03, B04, B05, B06, B41, B48, B49, B54

**D. RVI and Income Attestation**

Currently, pursuant to 08 OHIP/ADM-4, "Renewal Simplification for Medicaid and Family Health Plus Recipients", a recipient who has attested to resources can attest to income at renewal, provided s/he does not require long-term care services. This policy is tied systemically to RVI values, i.e., if an individual is attesting to resources because s/he is not receiving coverage of long-term care services, the RVI is 3 (Resources not verified) and s/he can also attest to income at renewal. Effective with the elimination of the resource test, RVI 9 will be used for cases in which there are no SSI-Related individuals, and they will be able to attest to income at renewal regardless of whether or not they are receiving community-based long-term care services.

If, however, a non-SSI-Related individual is in a mixed household, and the case RVI is 2 (Resources verified for current month) because the SSI-Related case member is authorized for community-based long-term care, the non-SSI-Related individual will be required to document income, resources, and a change of residency (which is also required for resource documenters) at renewal for purposes of redetermining eligibility for the SSI-Related case member.

**E. Medicaid Coverage for Nursing Home Care**

**1. Short-Term Rehabilitation**

Currently, an A/R who requires short-term rehabilitation for more than 29 days must document resources for the past 60 months or back to February 6, 2006, whichever is shorter, (60 months for trusts), in order for coverage to be provided beyond day 29. With the elimination of the resource test for non-SSI-Related individuals, only SSI-Related individuals will be required to document resources for coverage of short-term rehabilitation that lasts beyond 29 days.

**2. Temporary Placement in a Nursing Home**

An S/CC or ADC-Related individual who requires temporary nursing home care (i.e., the individual is expected to return home) is budgeted under community rules, and, therefore, will have no resource test. There is no durational restriction for temporary placement as long as medical evidence documents that the individual is expected to return home.

**3. Permanent Placement in a Nursing Home**

Unmarried ADC-Related and S/CC Medicaid recipients who are temporarily placed in a nursing home and subsequently become "permanently absent" will be budgeted using community budgeting rules until a disability determination is completed. Any excess income for the ADC-Related recipient is the individual's liability toward his/her nursing home care pending the disability determination.

Until the disability determination is complete, no resource test is applied; however, once disability is certified, a resource look-back for the past 60 months or to February 6, 2006, whichever is shorter, (60 months for trusts) must be done. The resource look-back begins with the first day of the initial institutionalization. The effective date of Chronic Care budgeting is the first day of the month following the 10-day notice of the change in the budgeting methodology.

The DOH-4319, "Long-Term Care Change in Need Checklist" and cover letter should be used to obtain the required resource documentation. When the "Access NY Health Care" application (DOH-4220) is revised to include Supplement A, it will be used when an increase in coverage is required.

For an institutionalized S/CC or ADC-Related individual who has a community spouse, spousal rules and definitions apply. Under spousal rules, a married person is an institutionalized spouse if s/he is in a medical institution or nursing facility and is likely to remain there for at least 30 consecutive days. Federal law states that spousal provisions apply "notwithstanding any other provision of law," i.e., despite the "no resource test" statute.

If an S/CC or ADC-Related individual in the community becomes in need of permanent nursing home care and applies for Medicaid, there will be no coverage for this service until the individual is certified disabled.

**F. Temporary Assistance Implications**

If an individual is in receipt of Temporary Assistance (TA) at the time of permanent nursing home placement, s/he will receive a personal needs allowance (PNA) of \$40 per month if there is no other income. In most instances, the individual will have other income that will make him/her ineligible for TA, and TA will be discontinued following the issuance of a 10-day notice.

For Medicaid purposes, coverage must continue unchanged until a Medicaid disability determination is made. Following the disability certification, a 10-day notice changing the liability toward the cost of care must be sent to the recipient.

**V. Systems Implications**

**A. Conversion of Existing RVIs/Coverage Codes for Non-Spenddown Cases**

**1. Upstate**

As part of the February 2010 WMS migration, existing RVIs of 1 (Resources verified for 36 months), 2 (Current resources verified), and 3 (Resources not verified) will be converted to RVI 9 in Case Type 20 cases where there are no SSI-Related individuals. Coverage Codes will also be converted (with certain exceptions) to full coverage (01). Until that time, when updating or renewing cases, the RVI codes should not be changed as per GIS 09 MA/27.

Recipients whose Coverage Codes are converted from 20 (Community Coverage without Long-Term Care) to 01 will receive an automated, one-time notice, advising them that their coverage has been changed to all covered care and services. Recipients authorized with Coverage Code 30 (PCP Full Coverage) will not receive this notice.

**2. New York City**

Budget Types 01 or 02 with an RVI 3, and at least one individual with Coverage Code 20 or 24 and an Authorization To Date greater than February 28, 2010, will have the Authorization From Date converted to 02/01/2010, and the RVI changed to 9. When the RVI is converted to 9, cases with Coverage Code 20 will be changed to 01 coverage, and cases with Coverage Code 24 (Community-Coverage without Long-Term Care (legal alien during 5 year ban)) will be changed to Coverage Code 11 (Legal Alien - Full Coverage). Affected recipients will receive an automated, one-time notice advising them that their coverage has been changed to all covered care and services.

At renewal, after the February 2010 migration, if all members of the case are other than Individual Categorical Code 10, 11, 12, 70, or 71, the worker should leave the RVI blank and the system will default the RVI to 9. Coverage will also default to 01 or 11 as appropriate. If at least one case member has Categorical Code 10, 11, 12, 70 or 71, the worker will be required to enter the appropriate RVI. The RVI will be ignored for individuals who are exempt from a resource test.

**3. Upstate and New York City: Non-SSI-Related Individual Requires Community-Based Long-Term Care Services**

If a non-SSI-Related individual with an RVI 3 requires home care after January 1, 2010, but before the February 2010 migration, the worker will need to change the RVI to 2 to allow the required coverage to be generated. Resource information should not be entered even if changing the RVI code from 3 to 2.

**B. Excess Income Cases**

Although non-SSI-Related Medicaid recipients with income over the applicable Medicaid income level are also exempt from a resource test, individuals authorized with spenddown Coverage Codes 21 (Community-Based Long Term Care) and 22 (Outpatient Coverage without Long Term Care) will not have their Coverage Code or RVI values converted automatically. The next time action is taken on the case, the Coverage Code should be changed to 02 (if the spenddown requirement has been met) and the RVI to 9.

**C. RVI Change for Mixed Households**

For Upstate and New York City, non-SSI-Related individuals in mixed households (SSI-Related individual in household), who are not subject to a resource test, will not have their coverage automatically converted. Districts should change non-SSI-Related household members' Coverage Code, as appropriate, the next time action is taken on the case. Since the RVI is selected for household members who have a resource test, the RVI should not be changed for mixed households.

**D. Medicaid Budget Logic (MBL) Changes for Budgets Effective January 1, 2010**

Upstate and New York City MBL changes were available January 4, 2010. Prior to that date, for FHPlus and non-SSI-Related Medicaid A/Rs who are not in mixed households, resource information should not be entered in the resource fields on MBL. As of January 4, 2010, entry of resource codes and resource values in MBL will be prohibited for Budget Types 01 and 02. For mixed households (Budget Types 05, 06, 09, and 10), it will be necessary to continue to collect resource information for non-SSI-Related A/Rs; however, the resource test will only apply to the SSI-Related Medicaid A/Rs. No change will be made for the entry of resource information for Budget Types 04, 07, or 08, as all members are SSI-Related and subject to a resource test.

**F. Effective Date**

The provisions of this Administrative Directive are effective January 1, 2010, for Medicaid budgets with an effective From Date of January 1, 2010 or later. Undercare cases affected by these changes will be converted in the February 2010 WMS migration or at the next client contact or renewal, whichever occurs first.



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