



Selfhelp Community Services, Inc.
520 Eighth Avenue
New York, NY 10018
212.971.7600

Valerie J. Bogart, Esq.
Director
Evelyn Frank Legal Resources Program
Direct Dial 212.971.7693
Fax 212.947.8737
vbogart@selfhelp.net

LEGAL RESOURCES PROGRAM UPDATE
September 13, 2004, revised Mar. 14, 2005

SUBJECT: Medicaid - New Rules for Verifying Resources and New Short-Term Rehabilitation Benefit

Effective September 1, 2004, there are two changes in the NYS Medicaid program:

1. New option for verifying an applicant's financial resources -- one may "attest" to the amount of resources on the application, rather than document them with actual bank statements, etc. This option is NOT available to anyone who needs nursing home care OR community-based long-term care services, such as personal care (home attendant care), long-term certified home health agency (CHHA) services, hospice, or adult day care. (See complete list attached). There is no real change for elderly or disabled applicants who need these services - they must still document resources -- except that the Simplified Asset Review form will no longer be used, as explained below.
 - Resource attestation may be used for QMB and SLIMB coverage. 04 OMM/ ADM-6 p. 5.
2. New service called "short-term rehabilitation"-- Until now, anyone needing Medicaid to pay for rehabilitation care in a nursing home had to provide 36 months of resource documentation. This was true even for short term stays, or where one needed Medicaid only to pay the Medicare co-insurance after 20 days of Medicare coverage. Now, even for a client who has done "simplified asset review," (no longer called by that name - see below), or who has merely attested to the amount of her resources, this new service is available -- but only for a very short period of time.
 - A. Short-term rehabilitation includes:
 - one period of Certified Home Health Agency (CHHA), up to a maximum of 29 consecutive days in a twelve-month period; and
 - one short-term nursing home admission, up to a maximum of 29 consecutive days in a twelve-month period. A recipient may receive one of each type of service for a total of 58 days in a 12-month period.
 - B. The 29 days must be consecutive. Client cannot spread it over two or more rehab stays in a year. EX: Client is transferred from the nursing home rehab program after only 15 days, and sent back to the hospital. The 14 remaining days of the 29-day maximum are lost and cannot be carried over. She would not qualify until the next year. She would have to do 36-month resource documentation to receive more nursing home care after the hospital stay.

C. Spend down cases - Attestors only need to meet a one-month spend-down requirement for Medicaid payment for each month during a 29-day period of short-term rehab. Note that the 6-month spend-down requirement for hospital care does not apply. ADM p. 10.

D. The 29-day short-term rehabilitation begins on the first day the applicant/recipient receives CHHA services or is admitted to a nursing home on other than a permanent basis, regardless of whether the client has Medicare or other insurance to pay for the early part of the stay, IF the client applies for Medicaid during that stay.¹

Example : A recipient is admitted to a nursing home for rehabilitation on November 8, 2004. Medicare covers November 8 through 27 (20 days) in full. Medicaid coverage for short-term rehabilitation is available starting November 28 through December 6 (the remaining 9 days of the short-term rehabilitation allowance).

Note: If the individual was not in receipt of Medicaid upon admission and applied for Medicaid coverage to begin December 1 (not retroactive to November), November 8 would still count as day one of the short-term rehabilitation.

Exception - If an individual does not apply for Medicaid coverage for a commencement of CHHA services or nursing home admission, that commencement/admission is not counted toward the one commencement/admission limit per 12-month period. So she needs to predict how long a stay might be to decide if it is worth applying for Medicaid for that stay

E. TIP -- Before client applies for Medicaid for nursing home care using the 29-day short-term Medicaid benefit, consider:

- whether client has Medicare with or without Medigap, and whether that insurance is expected to pay for most of the stay. If so, don't apply and waste the 29-day benefit. If client doesn't have Medigap for nursing home co-insurance, and stay is expected to be more than 20 days, Medicaid might be needed
- It is early or late in the year, and how likely it is that client will have a 2nd nursing home admission this year for which she'll need Medicaid. Use your crystal ball!

Example of Beating the Odds: Mrs. S applies for Medicaid coverage for a three-week nursing home stay which began on September 4, 2004. Six months ago she had a short-term nursing home stay but did not apply for Medicaid, expecting it to be less than 20 days and fully covered by Medicare. Medicaid coverage for short-term rehabilitation is available starting September 4, 2004.

Example of Losing the Gamble: The same Mrs. S had the same short-term stay six months ago. She applied for Medicaid for that stay, just in case she'd stay more than 20 days. She has no Medigap insurance so was concerned about the \$114/day co-insurance (2005). She left on Day 22, so Medicaid paid the coinsurance for 2 days using the short-term rehab benefit. For the 3-week nursing home stay beginning on Sept. 4, 2004, she has NO short-term Medicaid rehab coverage, even though she only used 2 days in the last stay. The days must be consecutive. She will have to do the full 36-month lookback to qualify for Medicaid to supplement the Medicare coverage. Next year she will have a new 29-day benefit.

MORE ON THE NEW RESOURCE DOCUMENTATION

The Three Ways of Verifying Resources -- each with a different service package

Before, there were two ways of verifying resources and two service packages -- Full Medicaid requiring a 36-month look back, or simplified asset review for community Medicaid. Now, a 3rd way has been added with a more limited services package. The 3 ways are described below, and on the attached chart. The resource LIMITS have not changed, only the three ways of documenting them. Client should indicate her choice of documentation on the attached unofficial Election form.

1. 36-month look back - 36 months of documentation (60 months for trust transfers) is needed for full Medicaid coverage, including nursing home care, Lombardi, and other waiver programs. This has NOT changed for the aged (65+), blind, and disabled, persons ages 19 - 21, or caretaker relatives of children under 21. NOTE: Pregnant women and children under 19 still have NO resource limit).

- The look back is 12 months for persons between the ages of 21 and 64 who are singles or in a childless couple, who are not pregnant, blind or disabled, and not a caretaker relative for a child under 21. Transfers to a trust are also a 12 month look back. This population may not use Medicaid spend down.

2. Actual documentation of resources in the month of application is needed for all community-based home and long-term care, (except Lombardi care, which requires 36 months). This is no longer called Simplified Asset Review. Before, it was presumed that 36-month look back was used unless the client specially requested Simplified Asset Review. The Simplified Asset Review form is NO LONGER NECESSARY, but client must be asked and must indicate which of the 3 options she wants.

- Any community-based applicant who may need any home care services or adult day care (see list), should use this option and not category 3 below -- the "resource attestation." It is not difficult to document current resources, and will eliminate headaches down the road of "upgrading" coverage.
- 3-month retroactive coverage is still available. Be sure to produce documentation of resources for the 3 months preceding the month of application if client needs Medicaid coverage or reimbursement for services rendered in the 3 months before application.

3. "Resource Attestation" -- NEW! One can "attest" to the amount of resources on the application, rather than document them with actual bank statements, etc. HOWEVER, this option is NOT available to anyone who needs nursing home care OR community-based home care services. (See complete list of services attached). The only long-term care service available is the new 29-day short term rehabilitation. See above

- Medicaid has the right to do a "collateral investigation" to verify the actual amount of resources, and may deny coverage if the resources exceed the regular limits. Medicaid will defer a pending application, and request verification, if they find resources that were not attested to. Application may be denied based on failure to verify in such cases.
- 3-month retroactive coverage should be available to applicants who "attest" - but be sure to "attest" to the resource amounts in that period.

- Resource attestation may be used for people applying for QMB and SLIMB. 04 OMM/ ADM-6 p. 5.

Recertifications (called Renewal) and Mid-Authorization Changes in Level of Coverage

- Renewal (recertification) packages received by mail in September 2004 and after will instruct the client to itemize her resources and send in documentation if she is receiving or wants to receive any long-term care services - whether home care or nursing home care
- Downgrading from a “Higher” Level of Coverage -- Applicants/recipients who fail to document resources sufficiently will no longer have Medicaid terminated or denied for failure to verify resources. Instead, coverage will be downgraded to the lowest “attestation” level, with no long term care coverage, or for those under 65, to Family Health Plus coverage, for which there is no resource limit. Notice with aid-continuing rights is required.
- Upgrading from a “Lower” Level of Coverage -- Someone authorized for a lower amount of coverage, i.e. through resource “attestation,” can be “upgraded” to more expansive long-term care coverage by submitting the necessary documentation with a request for long-term care coverage (nursing home and/or community). The effective date of the increased coverage will be the date of the client’s request. The district has 45 days to determine eligibility for the higher level of coverage. The client may also request this redetermination at renewal (recertification).
- IF RETROACTIVE COVERAGE Is needed in any of the 3 calendar months prior to a request for an expansion of coverage, be sure to submit documentation for the one to three months needed, and request that the effective date be retroactive.

Background, Directives, and Effective Dates: -- New Section 366-a(2) of the Social Services Law, enacted by Chapter 1 of the Laws of 2002, eliminated the resource documentation requirement for individuals not seeking Medicaid long-term care services.

- 04 OMM/ ADM-6 (July 20, 2004) implements the changes effective 8/23/04 but retroactive to 4/1/03, posted at <http://www.wnyc.net/pb/docs/04OMMADM6.pdf>
- The NYS Dep’t of Health further clarified the starting-date of the 29-day period in the February 2005 Medicaid Update, at <http://tinyurl.com/A8LXU3> and GIS 05 MA/004, at <http://tinyurl.com/97OB8D>.
“If you have any questions concerning Medicaid coverage of short-term rehabilitation under one of the new coverage codes, please contact the Medicaid eligibility staff at (518) 474-8887” Feb. 2005 Medicaid Update.
- For more information about the coverage and billing codes for attestation and the 29-day rehab benefit, see DOH Medicaid Update, August 2004, at <http://tinyurl.com/A2ZPD4>; and DOH Medicaid Update, July 2004, at <http://tinyurl.com/7GKRP9>.
- NYC Medicaid issued an ALERT explaining the changes on September 1, 2004 - <http://www.wnyc.net/pb/docs/Alert9-9-04.pdf> with attachments at <http://www.wnyc.net/web/news/XcNewsPlus.asp?cmd=view&articleid=3943>
- Emergency proposed rule amending 18 NYCRR 360-2.3(c)(3) published 3/16/05, eff. 2/25/05. <http://www.dos.state.ny.us/info/register/2005/mar16/pdfs/Rules.pdf>
- Q & A 05/OMM-INF - 2 June 8, 2005, at http://onlineresources.wnyc.net/pb/docs/05_inf-2.pdf

ELECTION FOR MEDICAID COVERAGE -
DOCUMENTATION OF RESOURCES

- I want full Medicaid coverage. I am submitting documentation of 36 months of assets.
 - I want retroactive coverage beginning _____, which is up to 3 months before the month of my application.
- I want coverage for community-based Medicaid only. I understand I will not be eligible for Medicaid to pay for nursing home care, Lombardi program and other home and community-based waiver services. Also,
 - I want coverage only beginning in the month I apply for Medicaid, so I am documenting my assets only for the month of application.
 - I want retroactive coverage for up to 3 months before the month of my application. I am submitting documents of my assets beginning in the month of _____, 200__.
- I attest to the fact that my countable resources are within the allowable limit for me and my household. I am not submitting any documentation of my resources. I understand that I and other members of my household are not eligible for any long-term care services in a nursing home or in the community, including home care, except for the short-term rehabilitation of up to 29 days.

I want only community Medicaid with no long-term care services and/or the Medicare Savings Program.

_____	_____	
Signature	Date	
_____	_____	
Name of Applicant (Printed)	Date of Birth	
_____	NY	_____
Address Street	City	Zip

Documentation of Resources for Medicaid in New York State - 9/1/04

Valerie Bogart, Selfhelp Community Services, 9/13/04 - adapted from 04 OMM/ADM-6, NYC HRA Medicaid Alert, and HRA presentation 9/10/04

Background, Directives, and Effective Dates: -- New Section 366-a(2) of the Social Services Law, enacted by Chapter 1 of the Laws of 2002, eliminated the resource documentation requirement for individuals not seeking Medicaid long-term care services. 04 OMM/ ADM-6, dated July 20, 2004, posted at <<http://www.wnyc.net/pb/docs/04OMMADM6.pdf>> implements the changes effective August 23, 2004 but retroactive to April 1, 2003. NYC issued an ALERT explaining the changes on September 1, 2004. The Alert is posted at <http://www.wnyc.net/web/news/XcNewsPlus.asp?cmd=view&articleid=3943>

	1 The Most Coverage	2 Intermediate Coverage	3 The Least Coverage
	Full Medicaid The Whole Package	Community Coverage WITH Community Long Term Care	Community Coverage WITHOUT Community Long Term Care
Resource Documentation	36-month look back for aged, blind, disabled, pregnant women, and children under 21 and their caretaker relatives. See note at end of table. 12-month look back for singles and childless couples age 21-65 who are not disabled. (Note: No spend down permitted for this group).	Proof of current resources (formerly "Simplified Asset Review") plus proof of resources in 3 months pre-application if retroactive coverage desired	Attestation - write in on application what current resources are without sending proof. Must itemize list of resources.
Coverage:			
Community care	All include hospitalization, clinic care, emergency care, care by a primary doctor and specialists, lab tests and x-rays, prescription drugs, medical transportation, medical surgical supplies, all outpatient care. Attestors are eligible for Medicaid managed care but not managed long-term care.		
Medicare Savings Program	Any type of verification may be used, INCLUDING Resource Attestation		
Long-Term Care services (institutional)	<ul style="list-style-type: none"> • Unlimited nursing home care • Hospice in a nursing home • Nursing home care provided in a hospital • Managed long term care in a nursing home • Intermediate care facility 	None of the services in box to the left are covered, except short-term rehabilitation - see below	

	1 The Most Coverage	2 Intermediate Coverage	3 The Least Coverage
	Full Medicaid The Whole Package	Community Coverage WITH Community Long Term Care	Community Coverage WITHOUT Community Long Term Care
Long-Term Care services in the Community	Lombardi program and other home and community-based waiver services	Not covered	
	<ul style="list-style-type: none"> • Unlimited CHHA care (certified home health agency) • Unlimited personal care/ home attendant care • Adult day health care (medical model) • Hospice in the community • Private duty nursing • PERS - personal emergency response system • Managed long term care in the community • CDPAP - Consumer directed personal assistance program (CONCEPTS) • Assisted Living Program (ALP) 	Not covered except for short-term rehabilitation - see below	
Short-term Rehabilitation in Nursing Home and CHHA - 29 consecutive days each	Unlimited nursing home and CHHA care is covered anyway, so this is not a new or added benefit	<ul style="list-style-type: none"> • CHHA - Unlimited CHHA care is covered anyway, so the 29 days is part of what existed anyway. • Nursing Home - The 29 consecutive days of rehab coverage is NEW. Before, Medicaid covered this only with 36-months of documentation. 	The 29-day CHHA plus 20-day Nursing Home rehab benefit is NEW and is the SOLE long-term benefit available for people who attest, who are not eligible for any other CHHA , home care, or Nursing Home coverage.

NOTE: Pregnant women and children under age 19 have no resource test as long as their incomes are below the applicable poverty level. <<http://www.health.state.ny.us/nysdoh/medicaid/mainmedicaid.htm>> However, if they need Medicaid and their incomes are above the applicable poverty level, the resource tests apply, with the new rules for verifying resources. Also, no resource test applies for the Breast & Cervical Cancer Treatment Program, Family Planning Benefit Program, and Family Health Plus program..