STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

INFORMATIONAL LETTER

TRANSMITTAL: 05 OMM/INF-2

TO: Local District Commissioners

DIVISION: Office of Medicaid Management

DATE: June 8, 2005

SUBJECT: Questions and Answers: Resource Attestation

SUGGESTED DISTRIBUTION:
Medicaid Staff
Fair Hearing Staff
Legal Staff
Staff Development Coordinators

CONTACT PERSON: Bureau of Local District Support
Upstate: (518) 474-8216
NYC: (212) 417-4500

ATTACHMENTS:
I. Request for Medicaid Coverage (available on-line)
II. Eligibility for Children in Waiver Programs (available on-line)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
04 OMM/ADM-6		360-2.3 360-4.4 360-4.6(b)	366-a(2) 366-c Ch. 1 of Laws of 2002		10/5/04 WMS/ CNS Coord. Ltr 9/7/04 WMS/ CNS Coord. Ltr. GIS 04 MA/020 GIS 05 MA/004

On August 4, 2004, the Department had a videoconference to inform social services districts of changes in the resource documentation requirements for Medicaid as required by Chapter 1 of the Laws of 2002. Beginning September 20, 2004, Medicaid applicants/recipients (A/Rs) who are subject to a resource test and who are not seeking coverage of long-term care services are allowed to attest to the amount of their resources rather than provide proof. Individuals who attest to the amount of their resources may qualify for short-term rehabilitation services. This videoconference discussed the new policy reflected in 04 OMM/ADM-6, "Resource Documentation Requirements for Medicaid Applicants/Recipients (Attestation of Resources).

The videoconference provided information on:

- Resource documentation requirements and Medicaid coverage options;
- Operational implications for social services districts;
- WMS changes to support attestation of resources;
- CNS implications; and
- Managed care implications.

A list of questions asked by social service districts and answers provided by the Department both during and subsequent to the videoconference follows.

I. POLICY

A. Applications/Renewals

Q1: What application form do we use for individuals who want to attest to resources? Do we alter the DOH-4220, "Access New York," application as the videoconference implied?

A1: Individuals who are not applying for long-term care can use the DOH-4220, including individuals over age 65. The DOH-4220 has been revised (8/04) to ask for a total resource amount rather than whether an individual is above or below the appropriate resource level for their household. Districts should continue to accept old versions of the DOH-4220 and may cross out the words "above" or "below" in Section I and record the total resource amount in the space provided.

Q2: When will the new DOH-4220 applications be available?

A2: A limited supply is currently available in the warehouse. We expect districts to continue to use the supply they have. As they re-order, they will get the new version. If the older applications are coming from a facilitated enroller, the district will get the total amount of resources from the "Eligibility Screening Worksheet."

Q3: Do applicants have to "itemize" their resources on the DOH-4220 application form if they are attesting?

A3: No, an individual who is attesting to the value of their resources is not required to itemize their resources at application.

Q4: Do we need a signature from an applicant saying the attested amount of resources is accurate?

A4: The signature on the application is sufficient. This applies to Family Health Plus (FHP) cases as well.

Q5: If an applicant indicates on the DOH-4220 that s/he does not currently have any resources, what should the district do?

A5: If the individual is otherwise eligible, Coverage Code 19 (Community Coverage With Community-Based Long-Term Care) should be given.

Q6: Is there a place on the revised DOH-4220 where applicants can check which Medicaid coverage option they are applying for?

A6: No, there is not.

Q7: Can a district require or request a signature indicating the coverage choice an applicant made?

A7: The Department will revise the DOH-4220 and LDSS-2921 to obtain the coverage choice made by an applicant. In the interim, districts can require a signature when the applicant is applying at the district. Districts may use Attachment I, "Request for Medicaid Coverage," for this purpose or a local equivalent approved by the Department.

Q8: Can people who are applying for inpatient care through a hospital use the DOH-4220?

A8: Yes. The DOH-4220 can be used for acute care.

Q9: How should the district process a pending Family Health Plus application where no resource amount was provided (old DOH-4220)?

A9: For Family Health Plus applications where the amount of resources is stated to be above the Medicaid resource level, districts should continue to process the applications for Family Health Plus. Districts should use Resource Code 91 in MBL. This code will be disabled.

Q10: The DOH-4220 does not ask whether the applicant/spouse owns a home. Will the application be revised to capture this information?

A10: The Department will revise the "Long-Term Care Change In Need Resource Checklist" (Attachment IV to 04 OMM/ADM-6) to capture this information. However, this attachment is currently being reproduced and made into a DOH form. Revisions will made when a new version is printed in approximately six to twelve months. There are no plans to change the DOH-4220 to capture this information.

Q11: The DOH-4220 does not have a section about recoveries from the estate of persons over age 55. Will the application be changed to include this information?

A11: Information concerning lien placement can be found in LDSS-4148A, "What You Should Know About Your Rights and Responsibilities (When Applying for or Receiving Benefits)." Information concerning recoveries can be found in LDSS-4148B, "What You Should Know About Social Services Programs: Questions and Answers." Since these booklets are provided to every applicant, the Department has no plans to revise the DOH-4220 to include information on liens and recoveries.

Q12: If a recipient applied using the DOH-4220 and now requires nursing home placement, is s/he required to complete an LDSS-2921 application for long-term care?

A12: No. If a Medicaid recipient requires an increase in Medicaid coverage, the individual must complete the "Long-Term Care Change In Need Resource Checklist" (Attachment IV to 04 OMM/ADM-6).

Q13: An applicant completed the DOH-4220 but at the interview indicates the need for long-term care services, must s/he complete an LDSS-2921 application?

A13: If the applicant completed the DOH-4220 and states that s/he needs long-term care at the interview, the district must have the applicant complete the "Long-Term Care Change In Need Resource Checklist."

Q14: If we get an LDSS-2921 application from someone who does not want long-term care coverage and wants to attest to the amount of his/her resources, can the individual just put a total amount on the form or do they have to enter an amount for each resource listed in the Resources Section?

A14: The instructions for completing the LDSS-2921 direct individuals to answer all questions on resources. However, if an individual writes in a total resource amount in the Resource Section rather than answering each question, the application should be accepted and processed for Community Coverage Without Long-Term Care.

Q15: If an individual who applies for Medicaid coverage for all care and services submits an LDSS-2921 application but does not submit the appropriate resource documentation, how does the individual attest to resources for Community Coverage Without Long-Term Care? Can the LDSS-2921 application somehow be used to record the amount of resources the individual is attesting to?

A15: Yes, provided the Resources Section has been completed and the district is aware of all resource amounts, the LDSS-2921 can be used for attestation purposes. If the applicant did not complete the Resources Section or did not know the amount of a particular resource when completing the application or during the interview, the applicant should be provided an opportunity to send in the missing information. If the applicant fails to provide the missing information, the district can deny the application based on failure to provide information about resources (not documentation but information).

Q16: Should we continue to use the "Previous Health Insurance" form when someone attests to their resources?

A16: The "Previous Health Insurance" (crowd out) form continues to be required for Medicaid applicants who submit an LDSS-2921 application form. If the DOH-4220 is used, this form is not required since questions about previous health insurance are included in the application.

Q17: When doing a Food Stamp/Medicaid interview, current resources are verified for Food Stamp eligibility. Is a separate resource attestation form completed for Medicaid?

A17: The application and resource documentation submitted for Food Stamp eligibility can be used for purposes of determining Medicaid eligibility for Community Coverage With Community-Based Long-Term Care. If a Food Stamp application is denied for failure to document resources, a separate Medicaid eligibility determination must be made.

Q18: Itemizing resources at renewal was discussed during the videoconference. Would this apply even if an individual attested at application?

A18: Yes, an attestor will be asked to list (itemize)current resources and amounts at renewal.

Q19: If the Resource Section of the renewal is returned without any information being filled in, can we presume that the recipient has no resources?

A19: No. The district must pursue a written statement from the recipient attesting to or documenting his/her current resource information.

Q20: It was stated that recipients must list their resources by type and amount at renewal. If a recipient does not itemize his/her resources, can the case be closed for failure to complete the renewal?

A20: No, if a recipient enters a total resource amount rather than an itemized listing or fails to complete the Resource Section altogether, the district should first contact the recipient and request the missing information. If the recipient does not supply the requested information, the case may be closed due to failure to provide resource information.

Q21: If at renewal someone documents current resources and has been on Medicaid for 3 years and documented resources during that period, is any further resource documentation required to meet the 36-month look-back?

A21: No. The individual has satisfied resource documentation requirements for the 36-month look-back and should be given Coverage Code 01 (Full Coverage), provided the individual has not transferred assets to or from a trust. Trust information is required for the past 60 months.

Q22: What coverage does the district give when an individual has attested to resources at renewal, and their case has been open for three years or more (previously documented resources)?

A22: If at renewal an individual elects to attest to resources rather than provide documentation and is otherwise eligible, Coverage Code 20 (Community Coverage Without Long-Term Care) should be given.

Q23*:* If a recipient is renewing for all covered care and services and does not document his/her current resources, is the Medicaid coverage changed from 01 (Full Coverage) to 20 (Community Coverage Without Long-Term Care) or from 02 (Outpatient Only) to 22 (Outpatient Coverage Without Long-Term Care) if there is a spenddown requirement and a one-month spenddown has been met?

A23: Yes. The Medicaid coverage would be changed from 01 to 20 and 02 to 22, respectively. This change requires 10-day notice. For example, if a notice is sent on January 17, the effective date of the change would be February 1. If a notice is sent on January 26, the effective date of the decrease in coverage would be March 1.

B. Short-Term Rehabilitation

Q1: Short-term rehabilitation is defined as "up to 29 days of skilled nursing care or Certified Home Health Agency (CHHA) services. Is it 29 days for both of these services or 29 days for each?

A1: An individual can receive 29 days of short-term rehabilitation in a nursing home and 29 days of CHHA services for a total of 58 days before being required to provide the applicable resource documentation.

Q2: When does Medicaid start counting a 29-day short-term rehabilitation stay?

A2: As notified in GIS message 05 MA/004, short-term rehabilitation begins on the first day the A/R receives CHHA services or is admitted to a nursing home on other than a permanent basis, regardless of the payor of the care and services.

Q3: Does the introduction of short-term rehabilitation change the way we look at temporary and permanent absence status?

A3: No, the definitions of temporary and permanent absence status do not change. These definitions determine when we do community or chronic care budgeting. Short-term rehabilitation is a time-limited service that will cover someone who has not been permanently placed in a nursing home. Short-term rehabilitation may be provided in spousal impoverishment cases, where the institutionalized spouse is expected to be in a medical facility for at least 30 days but the admission is not a permanent placement.

Q4: How do short-term rehabilitation in a nursing home and a temporary stay in a nursing home differ?

A4: Medicaid coverage of a temporary stay in a nursing home is not time-limited. A person can be in a temporary stay for as long as the treating physician in the nursing home indicates that the individual is expected to return home. Short-term rehabilitation in a nursing home can only be covered up to 29 days in a 12-month period under one of the limited Medicaid benefit packages before the individual would be required to provide resource documentation.

Q5: Does a worker need to see a doctor’s note confirming that the need for rehabilitation is short-term in order to authorize Medicaid coverage for a recipient?

A5: Once a worker has verified that a nursing home admission is not a permanent placement, a doctor’s note is not required for an individual to receive up to 29 days of rehabilitative nursing home care. No doctor’s note is required for CHHA services.

Q6: What happens if a recipient or their doctor states that the short-term rehabilitation is expected to last more than 29 days?

A6: As stated in the answer above, as long as a nursing home admission is not a permanent placement, the individual can qualify for up to 29 days of coverage for rehabilitation without documenting his/her resources. Resource documentation for the past 36 months (60 months for trusts) will need to be provided for coverage beyond day 29.

Q7: Does a short-term nursing home stay (respite) qualify as short-term rehabilitation?

A7: If the respite care is provided and covered as a Medicaid State Plan service, the care qualifies as short-term rehabilitation. Respite care provided as a waiver service under one of the home and community-based services waivers, does not qualify as short-term rehabilitation. If an individual receives respite care as a waiver service, the individual must provide resource documentation for the past 36 months (60 months for trusts), if not previously provided.

Q8: Does an applicant who has fully documented resources continue to have a 42-day per year respite care limitation?

A8: Yes. The recent changes to resource documentation requirements and coverage codes do not eliminate or change any of the program requirements for respite (short-term care stays).

Q9: Will people who are authorized for short-term rehabilitation in a nursing home appear on the nursing home roster?

A9: No. Individuals who are authorized for short-term rehabilitation must be entered on the Principal Provider Subsystem but workers should not enter an "R" (Roster) in the Card Code Field on Workbook Screen 5. These individuals should continue with their New York State Common Benefit Identification Card (CBIC). Because the district is required to send a copy of the notice authorizing short-term rehabilitation (Attachment II to 04 OMM/ADM-4) to the provider, the provider will know to bill Medicaid for the short-term rehabilitation.

Q10: For recipients whose short-term rehabilitation stay has been covered by Medicare, is this stay counted in the 12-month period?

A10: Yes. Regardless of the payor of the care and services, short-term rehabilitation begins the first day an A/R receives CHHA services or is admitted to a nursing home on other than a permanent basis.

Q11: If a person applies for short-term rehabilitation in a nursing home that has already exceeded 29 days and does not provide the 36/60 months of resource documentation required for day 30 onward, is the first 29 days covered by Medicaid under attestation rules?

A11: Yes. If the facility states that the admission is temporary and the individual has attested or provided current resource documentation and is otherwise eligible, the individual would be given the appropriate level of coverage, i.e., Community Coverage Without Long-Term Care or Community Coverage With Community-Based Long-Term Care, and the first 29 days would be covered by Medicaid. If, however, the facility states the admission is a permanent placement, the first 29 days would not be covered under short-term rehabilitation (attestation rules).

Q12: If the short-term rehabilitation stay exceeds 29 days or there is a second short-term rehabilitation stay within a 12-month period, resource documentation is now required for the past 36 months (60 months for trusts). If that documentation indicates that the individual was ineligible for the first 29 days covered under short-term rehabilitation, is this considered an overpayment subject to recovery?

A12: If the individual would have been otherwise eligible for Family Health Plus, then we do not consider the first 29 days Medicaid incorrectly paid. If, however, the individual is not otherwise eligible for FHP, the district may request voluntary repayment or pursue recovery for Medicaid incorrectly paid.

Q13: For purposes of Medicaid coverage of short-term rehabilitation, recipients with a spenddown need to meet a one month spenddown. When the 29 days spans two calendar months is the spenddown two months or one?

A13: An individual with a spenddown, must meet their one-month spenddown each month during the period of short-term rehabilitation. The spenddown amount for one month becomes the Net Available Monthly Income (NAMI) for each of the two calendar months. For example: An individual has a monthly spenddown of $100 and a short-term rehabilitation stay from January 26th to February 15th. There are no other medical bills to be used in January to meet the spenddown. Therefore, the person owes the nursing home $100 for January and $100 for February. On the Principal Provider Subsystem, the worker would enter $100 as the patient liability. If this same individual had already met his/her spenddown for January, the NAMI would be $0 for January and $100 for February.

Q14: How will the provider know when someone has used up their 29 days of short-term rehabilitation in a 12-month period?

A14: Nursing homes will receive notice of an individual's eligibility for Medicaid coverage of short-term rehabilitation through receipt of the "Authorization for Short-Term Rehabilitative Nursing Home Care" notice. CHHA providers have been instructed NOT to bill Medicaid beyond the 29th consecutive day if a recipient has one of the limited benefit packages (Coverage Code 19, 20, 24, 21 or 22). Currently, eligibility for short-term rehabilitation cannot be verified by the Medicaid Eligibility Verification System (MEVS).

Q15: How may a hospital social worker who wants to place a client in rehab as part of their discharge plan know if the client has already used their one occurrence of short-term rehabilitation from a previous placement by another hospital?

A15: Only the district can check to see if the individual has received short-term rehabilitation in the past 12 months.

Q16: A person has coverage for short-term rehabilitation. It is determined that the person is going to be in the nursing home for longer than 29 days, so the individual documents his/her resources for the past 36 months. Does the worker just change the Coverage Code to 01 (Full Coverage)?

A16: Yes, if the transaction to change the coverage is being made after the 29th day of short-term rehabilitation in the nursing home. In this instance, the new Upstate edit on Principal Provider would have already ended the short-term rehabilitation coverage. If a worker is switching coverage to 01 Coverage within the 29 days, the worker must also end-date the short-term rehabilitation stay on Principal Provider and input a new line for days 30 onward. If this is not done, the new edit will end the 01 Coverage after the first 29 days of admission.

C. Miscellaneous

Q1: Effective with this new policy, we allow individuals to attest to the amount of their resources. What if a person does not give us an amount for a particular resource? For example, at the interview, they say they have life insurance with a cash value but they don't know the amount. What is the district to do in this case?

A1: If an applicant does not know the amount of a particular resource, s/he should be given a due date to provide the information in writing to the district. If the information is not provided, the worker can deny the application. The only exception would be if based on what you do know about the person's other resources, the person has excess resources and would otherwise be eligible for Family Health Plus. In this situation, the applicant should be enrolled in Family Health Plus. Effective July 1, 2005, this exception would no longer apply due to the implementation of a resource test for Family Health Plus.

Q2: The ADM states that the attestation provisions were effective August 23, 2004 for all applications and case actions. What is the effective date for resource attestation?

A2: As notified in GIS 04 MA/020, implementation of resource attestation was delayed until September 20, 2004.

Q3: Applicants are no longer being denied Medicaid coverage due to failure to provide resource documentation. Instead, individuals will have eligibility determined for a lesser benefit package and will be informed of the services they do not qualify for. A) Isn't this the same as denying services? B) What are the available services for those who do not provide resource documentation? C) Will the special needs of that individual be met? D) How long will they receive the lesser benefit package?

A3: A) Establishing eligibility for a lesser Medicaid coverage package is not the same as denying Medicaid. However, in either case, the individual has the right to request a fair hearing to contest the decision made by the district. B) Individuals who attest to the value of their resources and are

determined otherwise eligible are entitled to Community Coverage Without Long-Term Care (See Attachments I and IX to 04 ADM-6 for a description of the services included). C) It is the applicant's choice whether to attest to the value or document the resources. If an individual needs long-term care, s/he must provide adequate resource documentation to establish eligibility for these services. D) A recipient may request an increase in coverage at any time.

Q4: I am still working on an older version of the DOH-4220 and the applicant attested to having resources below the Medicaid resource limit. The individual has not provided the requested resource documentation. Can I deny the application?

A4: No. If otherwise eligible, this individual should be given Community Coverage Without Long-Term Care (Coverage Code 20). Please note, as of March 1, 2005, facilitated enrollers were instructed to include a total resource amount on the DOH-4220 even if using an older version of the application.

Q5: What if there is a resource from the past on record and now the person claims none.

A5: The district should ask the individual to explain what happened to the resource.

Q6: Can an attestor get coverage under the Medicaid Buy-In Program for Working Persons with Disabilities?

A6: Yes, but the individual would only receive Community Coverage Without Long-Term Care (Coverage Code 20). If this person needed coverage for a long-term care service, such as home care or personal care services, appropriate resource documentation must be provided.

Q7: What would the Coverage Code be for a person who is eligible for the Medicaid Buy-In Programs for Working Persons with Disabilities?

A7: The coverage code would depend on the level of resource documentation provided. If otherwise eligible, an individual who attests to resources would receive Coverage Code 20 (Community Coverage Without Long-Term Care); an individual who provides current resource documentation would receive Coverage Code 19 (Community Coverage With Community-Based Long-Term Care); and an individual who provides documentation of resources for the past 36 months (60 months for trusts) would receive Coverage Code 01 (Full Coverage).

Q8: How can a recipient change Medicaid coverage?

A8: A recipient may request a change in his/her Medicaid coverage at anytime. In Upstate New York, the recipient would initiate the process by contacting their worker. In New York City, the recipient would initiate the process by visiting the Medical Assistance Program (MAP) office of their choice. In either circumstance, the worker would provide the recipient with a list of required resource documentation to be submitted to the worker, so that the recipient's eligibility can be determined for the requested change in coverage. An increase in coverage may be established for up to three months retroactive from the date the change in coverage is requested.

Q9: Who can intitiate a coverage change?

A9: Generally, only the recipient, the recipient's spouse or recipient's authorized representative can initiate a coverage change. However, if a district is informed by a facility that a resident's status has changed, the district should also treat this contact as a change in need request.

Q10: If a person attests to having excess resources, can we close or deny the case?

A10: If an individual is unable to reduce excess resources through the establishment of an irrevocable pre-need funeral agreement (or $1,500 burial fund if SSI-related) or incurred medical bills, eligibility for another program, e.g., Family Health Plus, must be determined. If the individual is not eligible for another Medicaid program, the case may be closed or denied with appropriate notice.

Q11: If a household has excess resources and wants to spenddown the excess on incurred medical bills to establish coverage, do we need to document that the resources are now at or below the Medicaid resource level?

A11: A household with excess resources must provide documentation of the incurred medical bills that will be used to reduce the excess if the household wants coverage for the month. There is no requirement that the recipient actually pay the bill or that they actually reduce the resources to the appropriate limit. After the initial certification period (six months for community cases and up to 12 months for an applicant in a medical facility), another comparison of resources to medical bills is required.

Q12: If at application an individual requests Community Coverage With Community-Based Long-Term Care and does not provide documentation of current resources but does attest to resources, what should the district do?

A12: After allowing the individual time to submit the missing resource documentation, the district should determine the individual's eligibility for Community Coverage Without Community-Based Long-Term Care (Coverage Code 20).

Q13: Since we only need to verify resources for the past 12 months for S/CCs, if they provide 12 months of resource documentation, are we correct in opening with Coverage Code 01 (Full Coverage)? These are the types of individuals who may end up in a nursing home due to a car accident. We have in the past, pursued a disability status for claiming purposes. If disability is approved, would we then have to lookback 36 months for resources (60 months for trusts)?

A13: If the individual is determined otherwise eligible, the case should be authorized with Coverage Code 01. If the individual subsequently requires nursing home care and it appears that the person may be disabled, the district should pursue a disability determination. If the individual is found disabled, a 36-month (60 months for trusts) lookback from the date nursing home coverage is requested would be required for full coverage. The 12 months of resource documentation already provided and any time spent on Medicaid since the initial authorization is applied toward the 36-month lookback period.

Q14: Someone in the community needs personal care, they apply for Medicaid, have been paying privately for care for three months preceding the application, and want to get reimbursed. Do they have to provide resource documentation for the first retroactive month in which they are seeking reimbursement?

A14: If the individual wants reimbursement for the three month retroactive period, s/he needs to document resources for each of the three months in the retroactive period.

Q15: When SSI recipients lose their SSI benefit and a separate Medicaid determination (Stenson) is completed, is the district required to complete a 36-month lookback?

A15: As explained in 92 ADM-23, “Medical Assistance Treatment for Recipients of Supplemental Security Income,” the responsibility for inquiring about transfers of assets rests with the Social Security Administration (SSA) as part of the SSI application process. Any information obtained by SSA regarding possible transfers is forwarded to this Department which then forwards the information to the local district. At such time as the recipient requires nursing facility services, the transfer should be evaluated and a penalty established, if appropriate. However, districts are not prohibited from doing the asset review for SSI recipients applying for nursing facility services or for SSI recipients who lose eligibility for SSI upon entering a nursing facility. A district can, at its option, request 36-months (60 for trusts) lookback information for both an SSI recipient in a nursing home and a former SSI recipient in a nursing home.

Q16: Does the term “simplified asset review” still exist?

A16: The term, “simplified asset review” referred to documenting current resources. The A/R was eligible for all services except nursing facility services. The new term for this level of resource documentation is “Community Coverage With Community-Based Long-Term Care.” One key difference is the inclusion of short-term rehabilitative nursing home care.

Q17: The ADM (04 OMM/ADM-6) states that an applicant may attest to or document current resources. What is meant by "current"?

A17: A first day of the month resource snapshot is still used for determining eligibility. Therefore, the term "current resources" means the amount of the resources as of the first day of the month during which the applicant wants coverage to start.

Q18: Can you explain the difference in how districts are to treat bank clearances and RFI hits?

A18: Bank clearances provide current resource amounts and the district can redetermine eligibility with this information. An RFI match, however, indicates that there is interest/income being generated by a resource. The district may or may not already know about the resource that is generating this interest/income, or the amount of interest/income being generated may lead the district to question the actual resource amount. If a district has cause to question a resource amount based on an RFI match, the recipient must verify/document the resource amount. Without this documentation/verification, eligibility cannot be redetermined.

Q19: What is the difference between home and community-based waiver services and non-waiver services in a home and community-based waiver program?

A19: Waiver services are generally non-medical in nature, e.g,, a home modification to widen the doors for a wheelchair. They are provided to someone who is participating in a waiver program. Thirty-six months (60 months for trusts) of resource documentation is required for individuals receiving waiver services.

A person can get non-waiver Medicaid services, such as personal care services, when participating in a waiver program. These services are referred to as State Plan services and are available to both waiver and non-waiver individuals.

Attestors cannot participate in a home and community-based waiver program.

Q20: Can individuals be admitted into the Long-Term Home Health Care Program <u>without</u> a waiver service? If yes, would they qualify if they documented "current resources only"? Would spousal budgeting be used?

A20: An individual can be enrolled in the Long-Term Home Health Care Program (LTHHCP) without receiving a discrete waiver service (respite, congregate and home-delivered meals, home modifications, home maintenance, social day care transportation, respiratory therapy, moving assistance, Personal Emergency Response System (PERS), nutritional counseling). Participation in all other waiver programs requires receipt of a waiver service. If a LTHHCP participant is not receiving a discrete waiver service, but is receiving a community-based long-term care service, e.g., personal care services, that individual

must document current resources. Spousal impoverishment budgeting would not be used if the recipient is not in receipt of a discrete waiver service.

Q21: Do children who participate in the Care at Home (CAH), Office of Mental Retardation and Developmental Disabilities (OMRDD), and Office of Mental Health (OMH) waivers have to provide resource documentation for the past 36 months (60 months for trusts)?

A21: Children who participate in the CAH and OMRDD waivers have a resource test and a 36-month lookback requirement. For the OMH waiver, however, it depends on whether the child is eligible under ADC or SSI-related budgeting. (See Attachment II for further information).

Q22: Are facilitated enrollers being trained on resource attestation?

A22: Information has been provided to facilitated enrollers regarding resource attestation policy and the actions enrollers must take. As of March 1, 2005, all facilitated enrollers will have implemented this policy. Facilitated enrollment procedures were shared with all Local Department of Social Service Commissioners in a letter dated February 1, 2005.

Q23: Under the attestor coverage, do we need an SSI-related applicant to show documentation for the $1,500 burial fund exemption and/or life insurance exemption?

A23: An SSI-related A/R can attest to having a $1,500 bank account as his/her burial fund. If the bank account contains more than $1,500, but the entire amount is intended to be spent on burial expenses, the A/R must put this in writing in order to be allowed the $1,500 burial exemption. An SSI-related A/R can also attest to the cash value and face value of his/her life insurance policy. If the total combined face value of the A/R's policies is equal to or below $1,500, the cash value is exempt.

Q24: How is managed care affected by attestation of resources?

A24: Attestors are eligible to enroll in managed care. Once the attestor is enrolled in managed care, the enrollee is 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.

Non-institutionalized individuals who want to enroll in a managed long term care plan must document their current resources in order to be eligible to participate. If institutionalized, such participants must provide resource documentation for the past 36 months (60 months for trust).

Q25: Is the Program of All-Inclusive Care for the Elderly (PACE) considered managed long-term care?

A25: Yes.

Q26: When using nursing home services (bill) to reduce a spenddown, is it the private or Medicaid nursing home rate that is allowed?

A26: Medical bills are used at the private pay rate to reduce a spenddown.

Q27: Regarding financial institution accounts held by an SSI-related individual who attests that she/he holds an account jointly with another individual, we assume that all the funds in the account belong to the SSI-related A/R. Rebuttals need to be documented and proof of separation of the funds submitted. With attestation, is it only necessary for the rebuttal to be made but not verified? Do we then also accept verbal confirmation that the funds have been separated?

A27: The district should continue to treat a jointly owned financial institution account as belonging to an SSI-related A/R. If an A/R wants to rebut this presumption, s/he must submit a written statement, along with corroborating written statements from the other account holders, submit account records for the months in question and separate the funds. The district has the authority to request this information, including verification that the money put in the account belonged to another party and that the account has been separated. If this does not occur, the district would count 100 percent of the account as belonging to the A/R.

Q28: If a Medicaid applicant has a history of either Temporary Assistance or SSI, are we required to complete a 36-month lookback every time they submit a new application for full coverage?

A28: If the individual was closed for a period of time, the district must review resources for only the period of time in which the case had been closed. The district does not need to review resources for the entire past 36 months unless the case had been closed for that length of time. See answer 17 in this section for information regarding a district's option to review resources for SSI recipients.

Q29: What does the new CNS language include?

A29: The new CNS language informs the recipient of the coverage for which they have been found eligible and lists those services for which no coverage has been authorized.

Q30: I have a Temporary Assistance (TA) applicant. Are there any different resource requirements for TA?

A30: No. TA applicants must still document their resources and will get full Medicaid coverage (Coverage Code 01). If a TA A/R fails to provide requested resource documentation, TA may be denied or closed, but a separate Medicaid eligibility determination must be made. For Medicaid-only purposes, the A/R can attest to resources.

Q31: Page 9 of the ADM (04 OMM/ADM-6) regarding budgeting for someone in permanent absence status who fails or refuses to provide adequate resource documentation seems contradictory. When there is a spouse, do we do spousal budgeting or regular community budgeting? The "Note" on page 9 in the ADM says they're not entitled to spousal budgeting, but the first paragraph implies we do spousal budgeting.

A31: When there is a community spouse with an institutionalized spouse in a medical facility and resource documentation is not provided, eligibility must be determined for Medicaid coverage of care and services outside the nursing home rate using a "hybrid" of community/spousal rules. Eligibility is determined as if it is the first partial month of institutionalization. The community spouse is entitled to a Minimum Monthly Maintenance Needs Allowance (MMMNA) and a Community Spouse Resource Allowance (CSRA). The following deductions are taken from the institutionalized spouse's income: (1) the $20 disregard; (2) Medicaid income level for one; and (3) community spouse monthly income allowance (CSMIA).

The note on page 9 refers to a waiver applicant. If an applicant for a home and community-based services waiver program does not provide adequate resource documentation to be eligible to receive a waiver service, the applicant is not entitled to spousal budgeting. An applicant must be in receipt of a waiver service in order for spousal budgeting to apply and must document resources for the past 36 months (60 months for trusts).

II. SYSTEMS

Q1: Do the new coverage codes apply to Case Type 22 as well as Case Type 20?

A1: No, the new coverage codes are for use only with a Case Type 20.

Q2: How does the system generate the appropriate coverage code for each person in a household?

A2: The system looks at the assigned Resource Verification Indicator (RVI) value for the case and the Categorical Code of each person in the household to default to the appropriate Coverage Code. As a reminder, in most situations, the system will only default to the following non-spenddown codes: 01, 10, 19, 20, and 24.

Q3: How should a worker select an RVI for a mixed household?

A3: A mixed household means there are family members with a resource test and family members with no resource test. The RVI code is based on the level of resource documentation provided for the family member(s) who has a resource test. For example, if there is a pregnant woman and husband in the household, the RVI would be selected based on the level of resource documentation provided. If the couple attested, the RVI would be "3" (Coverage Code 20 for the husband). If, instead, the couple documented current resources, the RVI would be "2" (Coverage Code 19 for the husband). In either situation, the wife would receive full coverage since she does not have a resource test.

Q4: What is "conversion?" Will Medicaid Coverage Codes be adjusted?

A4: On September 18 and 19, 2004, all currently active Case Type 20's were assigned an RVI value based on the existing coverage codes on the case. This conversion did NOT change any coverage codes.

Q6: Will recipients have incorrect coverage codes after conversion?

A6: Cases with Coverage Code 10 were assigned an RVI value of 4 (Transfer of Resources). For districts who also used this coverage code for individuals who requested a simplified asset review, the assigned RVI value will not be appropriate for the case. The RVI and Coverage Code should be changed at next contact or renewal.

Q7: What RVI values are going to be used for 06 (Provisional) and 02 (Outpatient) coverage when doing conversions?

A7: Cases with 06 or 02 coverage were assigned an RVI value of 1.

Q8: For individuals with no resource test (pregnant women and certain children), should we continue to use Coverage Code 01?

A8: Yes.

Q9: What is the difference between Coverage Codes 01 and 11 (Legal/Alien-Full Coverage)?

A9: There is no difference in the benefit package of coverage codes 01 and 11. Coverage Code 11 exists for tracking and editing purposes.

Q10: What happened to Coverage Code 06 (Provisional Coverage)?

A10: Coverage Code 06 is still "live" and is used when an individual has not yet met a spenddown requirement. When the individual meets a one-month spenddown and Coverage Code 02, 21, 22 or 23 is entered, the system will revert back to Coverage Code 06 after the month(s) of Outpatient Coverage.

Q11: What is the new Coverage Code for a recipient who documented resources at their last renewal and currently has 02 Coverage?

A11: The Coverage Code would now be 21 (Outpatient Coverage With Community-Based Long-Term Care).

Q12: Using the same scenario as that in question 11, what is the Coverage Code if the recipient has met a six-month spenddown?

A12: The Coverage Code would be 19 (Community Coverage With Community-Based Long-Term Care).

Q13: For someone who meets a six-month spenddown and is given one of the non-spenddown coverage codes, will coverage revert to 06 (provisional coverage) at the end of the six-month coverage period?

A13: Yes, if the case was initially authorized with 06 coverage and provided there is still time remaining in the authorization period, the coverage will revert back to 06 following a six-month period of coverage.

Q14: For Qualified Medicare Beneficiaries (QMBs) who attest to resources, do they still get 09 (QMB) coverage? Can they still apply using the one-page application?

A14: Yes, QMBs who attest to resources still receive Coverage Code 09 and may use the one-page application.

Q15: What Coverage Codes will Temporary Assistance be using since they are only required to provide current resource documentation?

A15: Individuals who are determined eligible for Temporary Assistance will continue to receive full coverage (Coverage Code 01).

Q16: How do managed care Coverage Codes fit in with resource attestation?

A16: The necessary systems changes have been made to allow individuals with Coverage Codes 19 (Community Coverage With Community-Based Long-Term Care), 20 (Community Coverage Without Long-Term Care) or 24 (Community Coverage Without Long-Term Care-NYC only) to enroll in managed care. Individuals with Coverage Codes 20 and 24 (attestors) are not permitted to enroll in managed long-term care.

Q17: What provisions have been made to prevent an attestor from enrolling in managed long-term care?

A17: This is system-controlled via Coverage Code 20. Coverage Code 20 will not be accepted as a PCP enrollment for managed long-term care.

Q18: How does the RVI correspond with Coverage Codes at the time of disenrollment from managed care for Medicaid fee-for-service coverage?

A18: The system looks at the RVI value, State/Federal Charge Code and/or Categorical Code to change to the appropriate Medicaid Coverage Code.

Q19: For Coverage Codes 19, 20, 21 and 22, nursing home care is prohibited. Do these Coverage Codes prevent billing of short-term rehabilitation services?

A19: Individuals with coverage codes 19, 20, 21 and 22 are eligible to receive short-term rehabilitative nursing home care and the coverage codes can be entered on the Principal Provider subsystem for payment. Individuals with these coverage codes are not eligible for nursing home care that exceeds 29 days. Upstate, a systems edit will automatically end coverage on the 29th day if the worker does not enter an end date.

Q20: If an applicant (other than an S/CC) states that a transfer has been made but does not provide documentation of the transfer, Coverage Code 19, 20, 21 or 22 is assigned based on the documentation that has been provided. The ADM states that these individuals are not entitled to short-term rehabilitative nursing home care, but these coverage codes do not prohibit payment of short-term rehabilitation. How can we prevent inappropriate payments?

A20: Medicaid payment for short-term rehabilitative nursing home care can only be made when a worker authorizes such payment by entering the stay on the Principal Provider Subsystem. If no entry is made, no payment will be made to the facility.

Q21: A new Coverage Code 23 has been established for a spenddown met situation where there has been a prohibited transfer (36/60 months resource documentation provided). Is there any new Coverage Code for 6-month spenddown met situation with a prohibited transfer? Or, do we use Coverage Code 10?

A21: For individuals who have met a six-month spenddown and made a prohibited transfer, Coverage Code 10 should be used during the transfer penalty period. Once the penalty period has expired, the district must change the Coverage Code from 10 to 02 or 01 depending on the status of the spenddown.

Q22: Can MBL Resource Type Code 98 still be used for "other" resources like a second vehicle?

A22: Yes. This code may be used either for the total amount of someone's resources or for a resource type where there is no specific MBL code.

Q23: I understand that the RVI value would be selected according to the resource documentation provided for individuals in the household who have a resource test but what about CNS opening codes. Have there been any changes to allow us to use different opening codes for individuals in a case (Screen 3)? For example, a pregnant mom would need C50 but an attesting dad would need S82. Without this system change we are still doing manual letters for all of these mixed households.

A23: CNS Upstate is set up at the case and individual level. Up to three individual level Reason Codes can be entered on Screen 3 provided they are all acceptances or all denials. Therefore, manual notices are not needed.

Q24: Have any CNS Reason Codes been deleted?

A24: Yes. Reason Code E-25 (spenddown to at or below the MA level) has been changed to S-28. This is because it is now a fill code.

Q25: For an individual with Coverage Code 02, 21, 22 or 23, is inpatient alcohol rehabilitation covered?

A25: These individuals are eligible for inpatient alcohol rehabilitation. However, at this time, Coverage Codes 02, 21, 22 and 23 must be changed to 01, 19, 20 and 10, respectively in order for payment to be made for the inpatient claim.

Q26: **What RVI Code should be used for individuals who qualify for Medicaid Extended Coverage under the New York State Partnership for Long-Term Care program?**

A26: Although Medicaid eligibility is determined without a resource test for these individuals, they do not have a unique Categorical Code; therefore, an RVI Code of 9 (exempt from resource verification) cannot be used. Districts should use RVI Code 1 (Resource Verification for 36 months) for these cases.

Kathryn Kuhmerker, Deputy Commissioner
Office of Medicaid Management

Attachment 1

REQUEST FOR MEDICAID COVERAGE

Instruction

Pregnant women and child(ren) under the age of 19 do not have to fill out this form.

Before filling out the below information, you should read the "Explanation of the Resource Documentation Requirements for Medicaid." It was given to you with your application and includes a list of long-term care services.

Print your name, check one of the boxes below and sign your name at the bottom:

I, _____, request that the Medical Assistance Program:

Determine my Medicaid eligibility for community coverage WITHOUT long-term care services.

I understand that I must tell you about the value of my resources beginning with the first month for which I am asking for Medicaid benefits. I understand that I will **NOT** be eligible for Long-Term Care Services.

I understand that at any time I may ask for Long-Term Care Services. If I need nursing facility services, I must give proof of my resources for up to 36 months (60 months for trusts) prior to my request for such services. If I need community-based long-term care services, I must give proof of my current resources.

Determine my Medicaid eligibility for community coverage WITH community-based long-term care services.

I understand that I must give proof of my current resources beginning with the first month for which I am requesting Medicaid benefits. I understand that I will **NOT** be eligible for nursing facility services.

I understand that at any time I may ask for nursing facility services. If I need nursing facility services, I must give proof of my resources for up to 36 months (60 months for trusts) prior to my request for such services.

Determine my Medicaid eligibility for all covered care and services.

I understand that I must give proof of my resources for the past 36 months (60 months for trusts) prior to the first month for which I am asking for Medicaid benefits.

_____ _____

Applicant or Authorized Representative Signature Date

_____ _____

Spouse (if applying) or Authorized Representative Signature Date

Return this completed form with your application to the local social services district.

Under the Home and Community-Based Services (HCBS) waivers (1915c), local districts have the authority to determine the Medicaid eligibility of a waiver child without consideration of parental income and resources.

This chart can be used to help determine the correct treatment of the waiver child's resources.

Waiver	**Resource Test**	**36/60 Month Lookback**
Care At Home I, II, III, IV, VI	***** Yes	Yes
OMRDD HCBS	Yes	Yes
OMH HCBS ADC-related Child SSI-related Child	 No Yes	 No Yes

***Child must first be determined ineligible under regular Medicaid rules (counting parental income and resources). If ineligible, parental income and resources are disregarded and an SSI-related budget is done for the child based on the child's income and resources.**