STATE OF NEW YORK
DEPARTMENT OF HEALTH

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TRANSMITTAL: 09 OHIP/ADM-3

TO: Commissioners of Social Services

DIVISION: Office of Health Insurance Programs

DATE: July 8, 2009

SUBJECT: Medicaid Extended Coverage for New York State Partnership for Long-Term Care Policyholders

SUGGESTED DISTRIBUTION:	Medicaid Staff Fair Hearing Staff Legal Staff Staff Development Coordinators
CONTACT PERSON:	Medicaid Eligibility Questions: Local District Liaison Upstate: (518)474-8887 New York City: (212)417-4500 New York State Partnership for Long-Term Care Questions: (518)474-0662
ATTACHMENTS:	See Appendix I for Listing of Attachments (I – VI)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
06 OMM/ADM-5 05 OMM/ADM-1 04 OMM/ADM-6 02 OMM/ADM-3 96 ADM-8 91 ADM-17		11 NYCRR 39	SSL 141.6, 209.6, 366, 366-c, 367-f NYS Insurance Law 3229	MRG pages 92.1, 251, 303.4, 352.1, 353.1, 478.a, 480	97 OMM/LCM-3 GIS 07 MA/020 GIS 07 MA/007 GIS 05 MA/001 GIS 04 MA/027 GIS 01 MA/022 GIS 98 MA/024

I. PURPOSE

This Administrative Directive (ADM) advises social services districts of the Medicaid Extended Coverage that is available to New York State Partnership for Long-Term Care program (Partnership) policyholders once certain benefits are exhausted. The Partnership is authorized by Section 367-f of the Social Services Law (SSL). Chapter 58 of the Laws of 2004, which amended SSL 367-f, expands the types of plans available under the Partnership program and the asset protection afforded by these plans for qualified Partnership policyholders.

II. BACKGROUND

The Medicaid program has become the primary source of funding for long-term care services. More than 80 percent of nursing days in New York State are paid by Medicaid. As the population continues to age and older New Yorkers require more care, funding of Medicaid becomes an urgent matter. In an effort to assist the elderly and the non-elderly poor (i.e., children, families, and disabled people of all ages), alternate ways to pay for long-term care services must be realized.

As an alternative means to fund long-term care, New York State was authorized to establish a Partnership for Long-Term Care demonstration program. The program was designed to assist New York State residents in planning for the cost of long-term care and to promote personal responsibility. This program, funded in part by a grant from the Robert Wood Johnson Foundation, promoted the availability of New York State approved long-term care insurance policies issued by participating insurers to residents of New York State.

The goal of the Partnership program is financial independence for consumers through shared responsibility. This means New York State will share with participating consumers in planning for their long-term care expenses. If an individual/couple purchases a Partnership for Long-Term Care insurance policy and keeps it in effect, the State will protect them, if otherwise eligible, against the costs of extended care situations through the Medicaid program.

Chapter 659 of the Laws of 1997, which amended SSL 367-f, made the Partnership program a permanent New York State program. This legislation provided asset protection for qualified Partnership policyholders in the event the policyholder used Medicaid Extended Coverage for their long-term care needs. Chapter 58 of the Laws of 2004, which amended SSL 367-f, expands the types of plans available under the Partnership program and the asset protection afforded by these plans. This expansion provides New York State residents with options for financing their long-term care coverage and protecting all or part of their resources under Medicaid Extended Coverage.

III. PROGRAM IMPLICATIONS

A. DEFINITIONS

This section provides definitions for the terms that are used in this ADM.

1. Asset Protection

The total asset protection or dollar-for-dollar protection from Medicaid resource spenddown requirements available under the Medicaid Extended Coverage feature of Partnership plans. Note when the term “asset” is used by the Partnership (e.g., in promotional materials, e-learning, etc.), it only includes a resource. It does not include income.

2. Dollar-for-Dollar Asset Protection (DDAP)

The amount of assets that is disregarded, up to the amount paid in benefits after using the Dollar-for-Dollar 50 or Dollar-for-Dollar 100 Asset plan, in determining a qualified Partnership policyholder’s eligibility for Medicaid Extended Coverage.

3. Long-Term Care Insurance

Insurance available through private insurance companies as a means for individuals to pay for needed care and protect themselves against the high cost of long-term care.

4. Medicaid Extended Coverage (MEC)

Medicaid that is available to a qualified Partnership participant who has met the minimum duration requirement under his/her policy. For Total Asset Protection plans, income is considered in determining Medicaid eligibility but resources are exempt. For Dollar-for-Dollar Asset Protection plans, income and unprotected resources are considered in determining Medicaid eligibility.

In the case of Total Asset Protection plans, no liens or recoveries will be pursued for correctly paid Medicaid payments made on behalf of qualified Partnership policyholders. In the case of a Dollar-for-Dollar Asset Protection plan participant, the amount of any lien or recovery against the participant’s estate will be reduced by the amount of asset protection provided to the participant as a qualified Partnership policyholder.

5. New York State Partnership for Long-Term Care (NYSPLTC) Insurance Policies

Long-term care insurance policies which are approved under the Partnership program by the New York State Insurance Department. The NYSPLTC program combines private long-term care insurance and Medicaid Extended Coverage to assist New Yorkers in covering the cost of long-term care. The Partnership requires that participating insurers provide benefit coverage, operational activities, and oversight that may not be applicable to long-term care insurance products sold outside the Partnership. Qualified Partnership policyholders have their Medicaid Extended Coverage eligibility determined based on income while all or a portion of their resources are exempt, depending on the type of plan purchased. Consumers who own long-term care insurance policies that are not Partnership-approved policies do not have their resources exempted in a Medicaid eligibility determination. Partnership policies can be identified by the Partnership logo which appears on all materials related to the Partnership program.

6. Participating Consumer

An individual who has signed the Partnership Consumer Participation Agreement and has purchased long-term care coverage pursuant to a Partnership approved policy/certificate from a participating insurer.

7. Participating Insurer

An insurance company offering policy/certificate coverage, approved under the New York State Insurance Department Regulation 144 (11 NYCRR 39) that signs the Insurer Participation Agreement. Insurers must submit products proposed for sale as Partnership for Long-Term Care policies for review and approval by the New York State Department of Insurance in order to be approved as a participating insurer.

8. Qualified Partnership Policyholder (QPP)

A participating consumer who has met the minimum benefit duration requirement of his or her New York State Partnership for Long-Term Care insurance policy and qualifies to apply for Medicaid Extended Coverage under the Partnership.

9. Tax-qualified Long-Term Care Insurance Contract

A long-term care insurance policy that provides favorable federal tax treatment for premiums and benefits paid by the policy. These policies must conform to the requirements of the federal Health Insurance Portability and Accountability Act of 1996 in order to have favorable tax status. Long-term care insurance policies that are approved as tax-qualified by the New York State Insurance Department also are provided favorable tax treatment by New York State.

10. Total Asset Protection (TAP)

Disregard of all of the qualifying Partnership policyholder's assets in determining his or her eligibility for Medicaid Extended Coverage, after the policyholder has used the required amount of benefits under a Total Asset 50 or Total Asset 100 insurance policy.

B. NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE INSURANCE PLANS

The Partnership program has four (4) plan offerings. They have different durational periods for nursing home and home care (community-based long-term care services). See Attachment I for the minimum duration requirements and benefit details for each of the plans.

There are two categories of Partnership policies, Total Asset Protection and Dollar-for-Dollar Asset Protection. The category selected determines the amount of resource protection under Medicaid Extended Coverage for a qualified Partnership policyholder.

1. Total Asset Protection Plan

The Total Asset Protection Plan (TAP) allows for the disregard of all of the QPP's assets in determining eligibility for Medicaid Extended Coverage. Under the Total Asset Protection Plan, there are two types of insurance policies.

a. **Total Asset 50** policies, identified by the number "**3/6/50**," provide a minimum benefit of:

- Three years in a nursing home; or
- Six years of home care (community-based long-term care services).

In order to be eligible for Medicaid Extended Coverage, a QPP must use benefits under the policy equal to 36 months of paid nursing home care or its equivalent. A combination of nursing home care, home care (where two days of home care equal one nursing home day), and certain other policy benefits may be used to satisfy this requirement.

b. **Total Asset 100** policies, identified by the number "**4/4/100**," provide a minimum benefit of:

- Four years in a nursing home; or
- Four years of home care (community-based long-term care services); or
- Four years in a residential care facility, such as an assisted living program.

In order to be eligible for Medicaid Extended Coverage, a QPP must use benefits under the policy equal to 48 months of paid nursing home care or its equivalent. A combination of nursing home care, home care, care in a residential care facility, and certain other policy benefits may be used to satisfy this requirement.

2. <u>Dollar-for-Dollar Asset Protection Plan</u>

The Dollar-for-Dollar Asset Protection Plan (DDAP) allows for the disregard of the QPP's resources under Medicaid Extended Coverage up to the total amount of benefits paid out by the participating insurer on behalf of the QPP. Under the Dollar-for-Dollar Asset Protection Plan, there are two types of insurance policies.

a. **Dollar-for-Dollar Asset 50** policies, identified by the number "**1.5/3/50**," provide a minimum benefit of:

- One and one-half years in a nursing home; or
- Three years of home care (community-based long-term care services), where two days of home care equal one nursing home day.

In order to be eligible for Medicaid Extended Coverage, a QPP must use benefits under the policy equal to 18 months of paid nursing home care or its equivalent. A combination of nursing home care, home care (where two days of home care equal one nursing home day), and certain other policy benefits may be used to satisfy this requirement.

b. **Dollar-for-Dollar Asset 100** policies, identified by the number "**2/2/100**," provide a minimum benefit of:

- Two years in a nursing home; or
- Two years of home care (community-based long-term care services); or
- Two years in a residential care facility, such as an assisted living program.

In order to be eligible for Medicaid Extended Coverage, a QPP must use benefits under the policy equal to 24 months of paid nursing home care or its equivalent. A combination of nursing home care, home care, care in a residential care facility, and certain other policy benefits may be used to satisfy this requirement.

A participating consumer may purchase a Partnership policy that exceeds the minimum required standards (basic coverage). However, additional coverage is limited as follows, depending on the type of policy purchased:

- Dollar-for-Dollar Asset 50 – Policies of greater duration than the minimum duration requirement shall not exceed two and one-half (2 ½) years of nursing home care and five (5) years of home care (community-based long-term care services); or

- Dollar-for-Dollar Asset 100 – Policies of greater duration than the minimum duration requirement shall not exceed two and one-half (2 ½) years of nursing home care, two and one-half (2 ½) years of home care (community-based long-term care services), and two and one-half (2 ½) years of care in a residential care facility.

Partnership insurance policy coverage that exceeds the minimum required standards for Medicaid Extended Coverage shall be used, like any other third-party health insurance, to offset Medicaid expenditures for the QPP.
Although the private insurance component of a Partnership policy may be used outside of New York State to pay for long-term care services, Medicaid Extended Coverage is only available for a QPP who is a resident of New York State. Regular residency rules apply to a QPP who is applying for Medicaid Extended Coverage.

C. IDENTIFYING A QUALIFIED PARTNERSHIP POLICYHOLDER (QPP)

The Partnership office in the Office of Long-Term Care (OLTC) is responsible for tracking the use of benefits of a Partnership policyholder as reported by the policyholder's insurance company. When a Partnership policyholder exhausts benefits to the point where qualifying status will be attained within 90 days of benefit utilization, the insurance company will notify the policyholder or the policyholder's designee that an application for Medicaid Extended Coverage should be initiated at the policyholder's local Department of Social Services (LDSS). The Partnership office also will receive a copy of the notification from the insurance company. A copy of this notice will be forwarded by the Office of Long-Term Care to the LDSS.

Different 90-day notices will be used, depending on whether the consumer is participating in the TAP or DDAP plan, and its minimum duration requirement. Attachment II, "90-Day Notice of Qualifying Status for Medicaid Extended Coverage (3/6/50 Plan)", and Attachment III, "90-Day Notice of Qualifying Status for Medicaid Extended Coverage (4/4/100 Plan)" are examples of the notices that will be sent to TAP plan policyholders. Attachment IV, "90-Day Notice of Qualifying Status for Medicaid Extended Coverage (1.5/3/50 Plan or 2/2/100 Plan)" is an example of the notice that will be sent to DDAP plan policyholders. Actual notices will be produced on insurance company letterheads. The notice will serve as verification to the LDSS that the applicant is a Partnership policyholder who is about to achieve qualifying status.

Under the Dollar-for-Dollar Asset Protection Plan, the amount of the QPP's resources that are protected is limited to the amount that the Partnership policy paid in benefits on behalf of the participating consumer. Therefore, the insurance company will send an additional notice(s) to the policyholder or the policyholder's designee specifying the amount that the Partnership policy paid in benefits. The Partnership office also will receive copies of the notices from the insurance company. Copies of the notice(s) will be sent by the Office of Long-Term Care to the LDSS and will serve as verification to the districts of the amount of resources to be disregarded in determining a DDAP QPP's eligibility for Medicaid Extended Coverage.

Examples of additional notices which will be sent on the insurance company's letterhead, depending on whether the participating consumer purchased a 1.5/3/50 or 2/2/100 DDAP insurance policy are Attachment V, "Cumulative Report of Benefit Usage (1.5/3/50 Plan or 2/2/100 Plan)" which provides the dollar amount of insurance benefits received to date and the dollar amount of any remaining benefit available under the policy, and Attachment VI, "Final Policy/Certificate Benefit Report (1.5/3/50 Plan or 2/2/100 Plan)" which is used to provide the final, total amount of benefits paid for qualified long-term care services.

D. MEDICAID EXTENDED COVERAGE (MEC)

QPPs generally will be related to the Supplemental Security Income (SSI) category of assistance because they are 65 years of age or older, or certified disabled or certified blind. However, if a QPP is under the age of 65 years and not certified blind or not in receipt of Social Security Disability benefits or Railroad Retirement benefits as "totally and permanently disabled," a disability review may be required.

With the exception of the treatment of resources, QPPs shall have their Medicaid determined in the same manner as other Medicaid applicants. Therefore, income rules that apply to other Medicaid applicants also are used for determining eligibility for QPPs applying for Medicaid Extended Coverage.

1. Total Asset Protection (TAP) Plan

The resources of the TAP QPP are exempt from consideration in determining Medicaid eligibility. In addition, if the TAP QPP is married, his/her spouse's resources are not considered in determining the QPP's Medicaid eligibility. Therefore, it is not necessary to collect and/or document information on the TAP QPP's resources or the resources of his/her spouse except to the extent that such information documents income derived from such resources.

In accordance with 96 ADM-8, "OBRA '93 Provisions on Transfers and Trusts," since resources are exempt from consideration in determining a TAP QPP's eligibility for Medicaid Extended Coverage, the transfer of resource provisions (i.e., look-back period and penalty period) do not apply. However, since income is not exempt, a transfer of a lump sum income payment or a stream of income during the look-back period may result in a transfer penalty. If an exempt resource that generates income is transferred, no transfer penalty may be imposed.

2. Dollar-for-Dollar Asset Protection (DDAP) Plan

To determine eligibility for Medicaid Extended Coverage, the DDAP QPP is allowed standard Medicaid resource exemptions in addition to the amount of his/her Partnership resource disregard. Therefore, the DDAP resource disregard applies to non-exempt resources.

The resources of a DDAP QPP are protected only up to the amount that the Partnership policy paid in benefits on behalf of the Partnership consumer. Therefore, only the dollar amount paid by the policy for benefits is exempted in determining the DDAP QPP's resource eligibility for Medicaid. In addition, if the DDAP QPP is married, his/her spouse's resources are counted to the extent that the couple's combined resources exceed the dollar amount paid by the Partnership policy for benefits. If the DDAP QPP is an institutionalized spouse, as defined in SSL 366-c, the couple's countable resources in excess of the community spouse resource allowance (CSRA), the dollar amount paid by the Partnership policy for benefits, and the Medicaid resource level for one are considered available for the institutionalized spouse's cost of care.

The DDAP resource disregard does not apply to specifically designated resources. The amount of the disregard would be applied toward whatever countable resources the A/R has at the time of application and renewal. If excess resources exist, the DDAP QPP can become eligible for Medicaid by spending down the excess resources by incurring or paying for medical expenses. See 91 ADM-17, "Treatment of Medical Assistance Applications When There are Excess Resources and Outstanding Medical Bills," for information regarding the spenddown of resources.

The collection and documentation of resources for the transfer of assets look-back period (up to 60 months) are required if a DDAP QPP applies for Medicaid coverage of nursing facility services and is determined to be otherwise eligible for Medicaid. If a DDAP QPP or his/her spouse made a prohibited transfer within the look-back period, the total cumulative amount transferred must be offset by any remaining dollar-for-dollar disregard that was not used toward the DDAP QPP's current countable resources. In cases where the uncompensated value of a prohibited transfer is entirely offset by the remaining amount of the dollar-for-dollar disregard, no transfer penalty is imposed. Any uncompensated transfer, or a portion thereof, not offset by the dollar-for- dollar disregard may result in a transfer penalty period.

Any dollar-for-dollar disregard amount used to offset a prohibited transfer cannot be used again for eligibility purposes, nor can the same dollar-for-dollar amount be used to offset any lien or recovery amount from the DDAP QPP's estate.

E. LIENS AND RECOVERIES

There are limited circumstances in which the costs of correctly paid Medicaid can be recovered by the LDSS (see Section IV.B. of 02 OMM/ADM-3, "Medicaid Liens and Recoveries"). The extent to which liens may be imposed and recoveries pursued with respect to Medicaid Extended Coverage that is correctly provided, depends on the type of plan chosen by the QPP.

1. Total Asset Protection (TAP) Plan

No lien may be imposed against the real property of a permanently institutionalized individual who is a TAP QPP. Furthermore, no recovery may be made from the estate of a TAP QPP.

2. Dollar-for-Dollar Asset Protection (DDAP) Plan

In certain circumstances, a lien shall be placed on the real property of a permanently institutionalized individual who is a DDAP QPP, based on the amount of unprotected resources. Information regarding when liens and recoveries apply is provided in Section IV. G. of this directive.

As noted in Section III. B., participating consumers may purchase policies providing benefits of a longer duration than the minimum required for Medicaid Extended Coverage. Coverage under Partnership policies that exceeds the minimum duration requirements will offset Medicaid expenditures for these QPPs. Therefore, the amount of any Medicaid liens or recoveries shall be reduced by any additional benefits paid by the Partnership policy on a dollar-for-dollar basis, IF the policy dollars have not already been used (e.g., to offset countable resources or an uncompensated transfer).

When the DDAP QPP has coverage beyond the minimum duration requirement, the participating insurer will notify the policyholder or the policyholder's designee of the benefits paid on a quarterly basis. The Partnership office also will receive a copy of this notice from the insurance company and will forward a copy to the LDSS.

Cumulative quarterly reports (see Attachment V) from the participating insurer provide the total dollar amount of Partnership benefits paid to date and the approximate dollar amount of remaining Partnership insurance benefits available for qualified long-term care services. Final reports (see Attachment VI) provide the final amount of total Partnership insurance benefits paid for qualified long-term care services on the QPP's behalf. This information will be used by districts to correctly calculate any estate recovery amounts for a DDAP QPP and/or to increase the dollar-for-dollar disregard in the event that a recipient's countable resources increase.

Note: A TAP or DDAP QPP is not required to have an irrevocable pre-need funeral agreement (IPFA). However, if one is established, any unused funds from the IPFA, after funeral and burial expenses have been paid, must go to the county, pursuant to Section 453 of the General Business Law and Section 209 of the Social Services Law.

F. ANNUITY REQUIREMENTS

Administrative Directive 06 OMM/ADM-5 specifies that as a condition of eligibility for nursing facility services the A/R must disclose a description of any interest the individual or the individual's spouse has in an annuity. In addition, for annuities purchased by the applicant or the applicant's spouse on or after February 8, 2006, the State must be named the remainder beneficiary in the first position or the purchase of the annuity will be considered an uncompensated transfer of assets. In cases where there is a community spouse, or minor or disabled child, the State must be named the beneficiary in the second position. If the annuity is purchased by or on behalf of the A/R, the annuity must meet the additional criteria listed in 06 OMM/ADM-5 or the purchase will be considered an uncompensated transfer of assets.

1. Total Asset Protection (TAP) Plan

TAP QPPs have their eligibility for Medicaid Extended Coverage determined without regard to resources. Since resources are exempt from consideration any annuity that the QPP or the QPP's spouse has purchased is exempt from the annuity requirements listed in 06 OMM/ADM-5.

2. Dollar-for-Dollar Asset Protection (DDAP) Plan

A DDAP QPP applying for Medicaid Extended Coverage is entitled to a resource disregard that is equal to the amount of long-term care benefits paid by his or her Partnership policy. If an annuity is a countable resource at the time of application for Medicaid Extended Coverage (e.g., a deferred annuity), the DDAP QPP may use the asset protection earned by the Partnership insurance to establish resource eligibility. If the DDAP is not sufficient to disregard the entire value of the annuity, any portion of the annuity value not disregarded is a countable resource for purposes of determining eligibility for Medicaid Extended Coverage. Regardless of whether the DDAP is sufficient to disregard the entire value of the annuity, the Dollar-for- Dollar Partnership policyholder or his/her spouse is not required to name the State as a remainder beneficiary of the annuity.

In cases where an annuity is not a countable resource (e.g., a qualified annuity in payment status) and the DDAP QPP is applying for Medicaid coverage of nursing facility services, the QPP and his/her spouse will be required to name the State as remainder beneficiary or else the purchase of the annuity may be treated as an uncompensated transfer. If the QPP or his/her spouse does not elect to name the State as remainder beneficiary, any DDAP disregard not used to establish resource eligibility may be used to offset the amount of the transfer (the purchase price of the annuity less any monies actually received from the annuity).

Note: The transfer provisions apply to annuities purchased on or after February 8, 2006, and within the transfer look-back period for Medicaid coverage of nursing facility services.

G. TREATMENT OF SUBSTANTIAL HOME EQUITY

Administrative Directive 06 OMM/ADM–5 specifies the home equity limit for Medicaid coverage of nursing facility services or community-based long-term care services. If an individual's equity interest in his or her home exceeds $750,000, the individual is not eligible for nursing facility services or community-based long-term care services, barring certain exceptions.

States can waive application of this home equity limit in cases where the State finds that applying the provisions would create an undue hardship. Using this authority, the Department expanded the undue hardship provision outlined in 06 OMM/ADM–5 to include QPPs, who otherwise might not qualify for Medicaid due to excessive equity value in their home.

When a QPP, with either TAP or DDAP, applies for Medicaid Extended Coverage for nursing facility services or community-based long-term care services, the $750,000 home equity limit does not apply.

Note: Consideration of a home as a countable resource or exempt homestead continues to apply for Dollar-for-Dollar Asset Protection policyholders.

IV. REQUIRED ACTION

A. 90-DAY NOTIFICATION OF QUALIFYING STATUS FOR MEDICAID EXTENDED COVERAGE

Upon receipt of the "90-Day Notice of Qualifying Status for Medicaid Extended Coverage" (for either the TAP or DDAP plan), the LDSS shall conduct a Welfare Management System (WMS) inquiry to determine if the QPP is known to WMS. If the QPP has an active Medicaid case, Medicaid would have been determined pursuant to standard income and resource rules. The LDSS worker shall record the Client Identification Number (CIN), case number, and certain identifying demographic information (date of birth and sex) on the 90-day notification letter. A copy of this letter with the added information must be forwarded to the Partnership office at:

New York State Partnership for Long-Term Care
New York State Department of Health
Office of Long-Term Care
Division of Long-Term Care Resources
One Commerce Plaza, Suite 826
Albany, New York 12260

If the QPP does not have an active Medicaid case or pending application, the 90-day notice shall be retained in a central location for ease of retrieval when the QPP applies for Medicaid Extended Coverage. In order to facilitate this process, LDSS staff must be aware that this information is being retained and whom they can contact to request a copy of this notice. If there is a pending Medicaid application for the QPP, the worker assigned to the case shall be contacted and a copy of the notice provided to the worker for the case record. LDSS procedures shall be followed to insure the worker is aware of the notice and has a copy for the case record.

B. CASE PROCESSING

The Medicaid Extended Coverage eligibility process for QPPs is the same as for other Medicaid applicants with one important exception, the treatment of resources.

Applications for Medicaid Extended Coverage shall be processed in a timely manner in accordance with Department regulations. In the event that additional information is required from the participating insurer (e.g., verification that the minimum duration requirement has been met and/or the dollar-for-dollar asset protection amount), the applicant or the applicant's representative shall be advised that the QPP's application is pending for receipt of this information.

The LDSS shall contact the insurer to access the needed information and record it in the case record. Verification can be made by means of a telephone conversation with the insurer. For DDAP QPPs, the LDSS also will receive copies of the attachments, completed by the participating insurer, which can be used to verify the dollar amount paid by the Partnership plan for the QPP.

QPPs generally will be related to the SSI category of assistance because they are 65 years of age or older, certified blind or certified disabled. However, the LDSS may initiate a disability review/determination for a QPP who is: under age 65; not certified blind or certified disabled; or not in receipt of Social Security Disability benefits or Railroad Retirement benefits based on a total and permanent disability.

C. DOCUMENTATION

The Medicaid Extended Coverage documentation requirements for QPPs are the same as for other Medicaid applicants/recipients, except for resource documentation for TAP QPPs.

1. <u>Total Asset Protection (TAP) Plan</u>

The resources of TAP QPPs are exempt from consideration in determining Medicaid eligibility. Therefore, it is not necessary to collect and/or document information on an individual's resources or the resources of his/her spouse except to the extent that such information documents income from resources.

LDSSs are encouraged to minimize the scope of investigation into the resources of such individuals unless such inquiries are related to either of the following:

a. Current income or anticipated income; or

b. Trusts in which the applicant or his/her spouse is named as creator (i.e., trustor, grantor, or settlor) or beneficiary in order to determine available income from the trust.

When completing the Medicaid application/renewal, the resource areas do not need to be completed except as noted above. Any income derived from the resource is to be listed under the income section of the application/renewal form. Similarly, when entering information on MBL, resources do not need to be entered. LDSSs should use an individual's income tax record together with any information obtained through Resource File Integration to assist in determining whether the individual's income streams are from resources.

2. Dollar-for-Dollar Asset Protection (DDAP) Plan

The resources of the DDAP QPP are exempt only in an amount equal to the dollar amount paid by the Partnership policy for benefits on behalf of the QPP. The uncompensated value of any prohibited transfer(s) made by the QPP or the QPP's spouse within the transfer of assets look-back period may affect Medicaid coverage for nursing facility services. Therefore, it is necessary to collect and document information on an individual's resources and, if married, his/her spouse's resources for up to the past 60 months if the DDAP QPP is applying for and otherwise eligible for nursing facility services.

If excess resources exist, the DDAP QPP is required to spend down the excess resources or incur medical expenses that would need to be paid out-of-pocket. Documentation of medical expenses incurred or paid to reduce excess resources is required. See 91 ADM-17 for information regarding spenddown of resources.

If the DDAP QPP does not provide resource documentation for the transfer of assets look-back period, eligibility for Medicaid coverage of nursing facility services cannot be determined. Medicaid coverage will be authorized based on the resource documentation provided.

For documentation purposes, districts should retain a copy in the case record of any 90-day notice, cumulative report, and final report, which has been submitted on the participating insurer's letterhead.

D. TREATMENT OF INCOME

Medicaid income rules that apply to other Medicaid applicants/recipients are used to determine Medicaid Extended Coverage for QPPs.

The QPP is required, as appropriate, to pursue or cooperate in the pursuit of income payments to which he/she is entitled (e.g., as an income beneficiary of a trust when the trustee has failed to make required income distributions). However, Medicaid Extended Coverage does not require the pursuit of income if the income payment would directly reduce the value of the "protected" resource from which the income payment is made. For example, periodic payments from an annuity may reduce the value of the protected annuity. QPPs cannot be required to take periodic payments or maximize income payments if this would directly reduce the protected resource value of the annuity.

If, however, the amount of the interest earned, which would have been added to the value of a retirement fund (e.g., an annuity), can be withdrawn, Medicaid requires the TAP or DDAP QPP to pursue or cooperate in the pursuit of the amount of this income. This is because the amount of earned interest would not reduce the value of the "protected" resource (e.g., the annuity principal). The QPP is not required to pursue or cooperate in the pursuit of the amount of interest earned in a retirement fund if his/her periodic payments are equal to or more than this amount. This policy of counting the amount of interest earned in a retirement account only applies to QPPs who are subject to chronic care budgeting.

In accordance with GIS 04 MA/027, most interest and dividends derived from resources are excluded as income for SSI-related A/Rs. See GIS 04 MA/027 and GIS 05 MA/001 for a list of interest/dividend income which is countable for SSI-related A/Rs. This interest/dividend exclusion only applies to community budgeting. It does NOT apply to chronic care budgeting, including spousal impoverishment budgeting.

Periodic payments received by an SSI-related QPP from an annuity and/or IRA continue to be treated as countable unearned income. Capital gain distributions (e.g., from mutual funds) noted on Internal Revenue Form 1099-DIV, Dividends and Distributions, whether paid as cash or reinvested, continue to be treated as unearned income as well.

E. TREATMENT OF RESOURCES

The treatment of resources for the purpose of determining the QPP's eligibility for Medicaid Extended Coverage depends on the category of the QPP's policy.

1. Total Asset Protection (TAP) Plan

The resources of the TAP QPP are exempt from consideration in determining eligibility for Medicaid Extended Coverage. In addition, if the TAP QPP is married, his/her spouse's resources are not considered in determining eligibility for Medicaid Extended Coverage.

2. Dollar-for-Dollar Asset Protection (DDAP) Plan

The resources of the DDAP QPP are protected only up to the amount that the Partnership policy paid in benefits on behalf of the QPP. In addition, if the DDAP QPP is married, his/her spouse's resources shall be counted to the extent that their combined resources exceed the dollar amount paid by the Partnership policy for benefits and the applicable Medicaid resource standard. The two DDAP QPP examples that follow use figures/levels for 2009.

a. If the DDAP QPP is an institutionalized spouse, as defined in SSL 366-c, the LDSS shall determine the resources considered available to the institutionalized spouse's cost of care as follows:

From the couple's total combined countable resources, subtract the following in the order listed:

1. The applicable community spouse resource allowance (CSRA);

2. The dollar amount paid by the Partnership policy on behalf of the QPP; and

3. The Medicaid resource level for one.

The remainder is the excess resource amount considered available for the institutionalized spouse's cost of care.

Example #1: A couple with an institutionalized spouse, who is a DDAP QPP, had combined total countable resources of $400,000 at the time of the institutionalized spouse's admission to a nursing home and $300,000 ($100,000 paid toward nursing home costs) when application for Medicaid Extended Coverage was made. The Partnership policy has paid $176,000 for benefits on behalf of the DDAP QPP.

	$300,000	Couple's combined total countable resources
-	$109,560	Minus CSRA
	$190,440	Remainder
-	$176,000	Minus dollar amount paid by the Partnership policy on behalf of the DDAP QPP
	$ 14,440	Remainder
-	$ 13,800	Minus Medicaid resource level for one
	$ 640	Excess resources considered available for the DDAP QPP's (institutionalized spouse's) cost of care

Prior to authorization of Medicaid Extended Coverage, medical expenses at least equal to $640 (i.e., the excess resource amount) would have to be incurred or paid. Excess resources also can be reduced by creating a burial fund of up to $1500 for the applicant or the applicant's spouse or an irrevocable pre-need funeral agreement.

b. If the DDAP QQP is married and in receipt of community-based long-term care services, the LDSS shall determine the QPP's resource eligibility as follows:

From the couple's total combined countable resources, subtract the following in the order listed:

1. The dollar amount paid by the Partnership policy on behalf of the QPP; and

2. The Medicaid resource level for two.

The remainder is the excess resource amount.

Example #2: An SSI-related couple has combined total countable resources of $220,000 when the DDAP QPP, who is in receipt of home care services, applies for Medicaid Extended Coverage. The Partnership policy has paid $194,000 for benefits on behalf of the DDAP QPP.

	$220,000	Couple's combined total countable resources
-	$194,000	Minus dollar amount paid by the Partnership policy on behalf of the DDAP QPP
	$ 26,000	Remainder
-	$ 20,100	Minus Medicaid resource level for two
	$ 5,900	Excess resources considered available for the DDAP QPP's cost of care

Prior to authorization of Medicaid Extended Coverage, medical expenses at least equal to $5,900 (i.e., the excess resource amount) would have to be incurred or paid. Excess resources also can be reduced by creating a burial fund of up to $1,500 for the applicant and up to $1,500 for the applicant's spouse or an irrevocable pre-need funeral agreement.

F. TREATMENT OF TRANSFERS

All Medicaid income rules apply to QPPs. Therefore, the prohibited transfer of a **stream of income**, like a pension (as opposed to the transfer of an income-generating resource), can result in a transfer penalty. The treatment of a transfer of **resources** is dependent on the category of Partnership policy.

1. Total Asset Protection (TAP) Plan

Administrative Directive 96 ADM-8, "OBRA '93 Provisions on Transfers and Trusts," advised that since resources are exempt from consideration in determining a TAP QPP's eligibility for Medicaid Extended Coverage, transfer of resource provisions (i.e., look-back and penalty period) do not apply.

2. Dollar-for-Dollar Asset Protection (DDAP) Plan

Resources are disregarded up to the amount paid in benefits by the DDAP Partnership policy. For DDAP QPPs applying for Medicaid coverage of nursing facility services, the uncompensated value of any prohibited transfer(s) made by the QPP or the QPP's spouse within the transfer of assets look-back period may affect eligibility. The amount of any DDAP not used to establish resource eligibility may be used to offset the amount of any uncompensated transfer.

If the remaining DDAP amount is **LESS** than the amount of the prohibited transfer, a transfer penalty period is calculated based on the uncompensated value of the difference (i.e., the remainder). The begin date of the transfer penalty depends on whether the transfer was made before February 8, 2006, or on or after February 8, 2006. See 06 OMM/ADM – 5 for information concerning transfer of assets provisions.

If the remaining DDAP amount **EQUALS or EXCEEDS** the amount of the prohibited transfer, no transfer penalty is imposed as the resource amount of the transfer has been "protected" by the DDAP policy.

Districts must keep track of the amount of any DDAP used to offset an uncompensated transfer since this disregard amount cannot be used for purposes or redetermining eligibility at renewal. An example follows:

> A QPP, with a $200,000 DDAP plan, total countable resources of $175,000 and a $20,000 uncompensated transfer is approved for Medicaid Extended Coverage of nursing facility services. Eligibility was achieved by using $175,000 of the asset protection to exempt the countable resources, leaving $0 in countable resources and $25,000 in remaining asset protection.
> From the $20,000 uncompensated transfer, the Medicaid resource level for one was subtracted ($20,000 - $13,800(effective 1/1/09)) leaving $6,200 as the uncompensated transfer. The uncompensated transfer ($6,200) was offset by a portion of the remaining $25,000 dollar-for-dollar disregard. The DDAP QPP was not subject to a transfer penalty. The district must note in the case record that $6,200 of the DDAP was used to offset a transfer of assets as this amount cannot be reused at renewal. At renewal, resource eligibility will be determined using a DDAP of $193,800 ($200,000 - $6,200).

Note: If the DDAP plan continues to pay benefits, the dollar-for-dollar disregard would increase by the amount of benefits paid out since the eligibility determination.

G. IMPOSITION OF LIENS AND RECOVERIES

The extent to which liens may be imposed and recoveries pursued with respect to Medicaid Extended Coverage that is correctly provided, depends on the type of plan chosen by the QPP.

1. Total Asset Protection (TAP) Plan

The LDSS may not impose a lien on the real property of a permanently institutionalized individual who is a TAP QPP. Furthermore, the LDSS may not recover from the estate of the TAP QPP. A lien placed on an A/R's home, when he/she was determined eligible using standard Medicaid income and resource rules, should be removed if the A/R subsequently becomes a TAP QPP who is eligible for Medicaid Extended Coverage.

2. Dollar-for-Dollar Asset Protection (DDAP) Plan

a. If an SSI-related DDAP QPP is permanently institutionalized and owns real property that is disregarded or exempt in determining Medicaid eligibility, a lien shall be placed by the LDSS on the real property to recover the amount by which the fair market value of the property exceeds the amount of the DDAP QPP's protected asset amount, if:

- The real property is the QPP's homestead (because the QPP has expressed an intent to return home or because a family member resides in the home) but none of the following relatives reside in the home:
  - Spouse;
  - Minor child;
  - Certified blind or certified disabled child of any age;
  - Sibling with equity interest in the home, who resided in the home at least one year prior to the QPP's admission to the medical institution.

OR

- The real property is income producing property used in a trade or business.

b. Recovery from the estate, if:

1) the DDAP QPP either died as a permanently institutionalized individual OR was 55 years of age or older when he/she received Medicaid; AND

2) an estate recovery would otherwise be allowed under the terms of Section IV.B. of 02 OMM/ADM-3, "Medicaid Liens and Recoveries,"

THEN the LDSS should seek a recovery, up to the amount of Medicaid furnished to the QPP, from estate assets that are in excess of the QPP's dollar-for-dollar asset protection.

3. Miscellaneous

As noted in Section III B. and E.2., participating consumers may purchase policies providing benefits of a longer duration than the minimum required for Medicaid Extended Coverage. Coverage under Partnership policies that exceeds the minimum duration requirement will offset Medicaid expenditures for these QPPs. Therefore, the amount of any Medicaid liens or recoveries shall be reduced by any additional benefits paid by the Partnership policy on a dollar-for-dollar basis, if the policy dollars have not already been used (e.g., to offset countable resources).

Liens and recoveries may be made by the LDSS for incorrectly paid Medicaid for TAP and DDAP QPPs, in accordance with 02 OMM/ADM-3, "Medicaid Liens and Recoveries."

H. ADDITIONAL INFORMATION

If a QPP fulfills the minimum duration requirement for receiving benefits any time after the first day of the month, eligibility for Medicaid Extended Coverage must be determined retroactive to the first day of that month with either no resource test under the TAP plan or the dollar-for-dollar disregard under the DDAP plan, whichever is applicable. If a participating consumer applies for Medicaid for any month prior to the month that the minimum duration requirement has been fulfilled, Medicaid eligibility for the applicant shall be determined under standard Medicaid resource (and income) rules.

All or a portion (depending on the policy purchased) of a QPP's resources and his/her spouse's resources are protected ONLY in determining the QPP's eligibility for Medicaid Extended Coverage. In the event that a QPP's spouse, who is not a participating Partnership consumer, applies for Medicaid, eligibility for the non-QPP spouse shall be determined using standard Medicaid rules. Consequently, the QPP's protected resources, under either the TAP or DDAP plan, may be considered available for purposes of determining the non-QPP's Medicaid eligibility.

V. SYSTEMS IMPLICATIONS

A. WMS (WELFARE MANAGEMENT SYSTEM)

Although TAP QPPs are not required to verify resources, including resource documentation for up to the past 60 months, a Resource Verification Indicator (RVI) of "1" (resources verified for up to the past 60 months) must be entered in the RVI field on "WKUM01." For DDAP QPPs, the RVI value should be selected based on whether the DDAP QPP is in need of Medicaid coverage for nursing facility services. RVI "1" should be used for coverage of nursing facility services and RVI "2" (current resources) for all other care and services.

Restriction/Exception (R/E) codes 75 and 76 have been created to identify the QPPs. R/E code 75 should be entered when the DDAP QPP is authorized for Medicaid Extended Coverage. R/E code 76 should be entered when Medicaid Extended Coverage is authorized for a QPP with TAP. The start date of the restriction should equal the authorization from date for Medicaid Extended Coverage.

B. MBL (MEDICAID BUDGET LOGIC)

There are no MBL implications. Resources that are not counted due to the dollar-for-dollar disregard should not be entered on MBL when calculating a budget. A note should be made in the case record identifying the resources (or transfer of resources) used to offset the dollar-for-dollar disregard.

VI. EFFECTIVE DATE

The provisions of this ADM are effective July 13, 2009, retroactive to August 20, 2004.

Deborah Bachrach

Deborah Bachrach, Deputy Commissioner
Office of Health Insurance Programs

LISTING OF ATTACHMENTS

(Available On-line)

Attachment I	Minimum Duration Requirements and Benefits For Partnership Plans
Attachment II	90-Day Notice of Qualifying Status for Medicaid Extended Coverage - Total Asset Protection Plan (3/6/50)
Attachment III	90-Day Notice of Qualifying Status for Medicaid Extended Coverage – Total Asset Protection Plan (4/4/100)
Attachment IV	90-Day Notice of Qualifying Status for Medicaid Extended Coverage - Dollar-for-Dollar Asset Protection Plans – (1.5/3/50 and 2/2/100)
Attachment V	Cumulative Report of Benefit Usage - Dollar-for-Dollar Asset Protection Plans – (1.5/3/50 and 2/2/100)
Attachment VI	Final Policy/Certificate Benefit Report - Dollar-for-Dollar Asset Protection Plans – (1.5/3/50 and 2/2/100)

Attachment I

Minimum Duration Requirements and Benefits for Partnership Plans

TOTAL ASSET (RESOURCE) PROTECTION	DOLLAR-FOR-DOLLAR ASSET (RESOURCE) PROTECTION

Total Asset 50	Total Asset 100	Dollar-for-Dollar 50	Dollar-for-Dollar 100
Duration:	Duration:	Duration:	Duration:
3 years nursing home; or	4 years nursing home; or	1.5 years nursing home; or	2 years nursing home; or
6 years home care;* or	4 years home care; or	3 years home care;* or	2 years home care; or
Equivalent combination	4 years residential care facility; or	Equivalent combination	2 years residential care facility; or
	Equivalent combination		Equivalent combination
Benefit:**	Benefit:**	Benefit:**	Benefit:**
$218/day for nursing home care; or	$218/day for nursing home care; or	$218/day for nursing home care; or	$218/day for nursing home care; or
$109/day for home care	$218/day for home care or residential care facility	$109/day for home care	$218/day for home care or residential care facility

* Two home care days equal one nursing home day
** Minimum Benefit Levels for 2009

90-DAY NOTICE OF QUALIFYING STATUS FOR MEDICAID EXTENDED COVERAGE

(space for policyholder's or designee's name and address)

Dear Partnership Policy/Certificate Holder:

According to our records, you will meet the minimum benefit duration requirement of your New York State Partnership for Long Term Care Insurance policy/certificate (i.e., 1,095 days of nursing home care, or 2,190 days of home care, or a combination of the two) within approximately 90 days of continued benefit use. At that time, you may qualify for Medicaid Extended Coverage under the Partnership. As a Qualifying Partnership Policy/Certificate Holder (QPP) under this program, you can apply for Medicaid Extended Coverage for your continuing long-term care needs without regard to your assets.

To apply for Medicaid Extended Coverage, you must contact the Local Department of Social Services (LDSS) in the county where you reside. If you are residing in a nursing home or an adult residential care facility, your county of residence for Medicaid purposes should, in most instances, be the county where you were residing prior to your admission. The LDSS is responsible for conducting the Medicaid Extended Coverage eligibility process.

To facilitate the transition in payer sources for your care from private insurance benefits to Medicaid Extended Coverage, you are encouraged to contact your LDSS and initiate the Medicaid Extended Coverage application process as soon as possible. The telephone number of the appropriate LDSS office appears in the blue pages of your telephone directory under County Government, Department of Social Services.

This notice will serve as verification to the LDSS that you are expected to attain QPP status within 90 days. The precise date on which Medicaid funding may commence will depend on:

- the date you apply for Medicaid Extended Coverage;

- the date on which you exhaust three years (1,095 days) of nursing home care or six years (2,190 days) of home care or a combination of the two; and
- whether you are found otherwise eligible for Medicaid; for example, whether you are income-eligible for Medicaid.

The approximate date when you will meet the minimum benefit duration requirement of your New York State Partnership Long Term Care Insurance policy/certificate is listed below. You will need to provide this letter to your LDSS to verify your QPP status. In addition, as part of the Medicaid Extended Coverage application process, the LDSS will request that you provide information pertaining to your financial status, particularly your income. While assets are exempt from consideration in determining Medicaid Extended Coverage eligibility, the LDSS will ask you to document your assets to the extent that they produce income.

Policy/Certificate Holder:
SSN:
Date of 90-Day Notice:
Approximate date of satisfying minimum benefit duration requirement:
Approximate number of benefit days available before policy/certificate benefits are exhausted:
Insurer Toll-Free Telephone Number for inquiries:

90-DAY NOTICE OF QUALIFYING STATUS FOR MEDICAID EXTENDED COVERAGE

(space for policyholder's or designee's name and address)

Dear Partnership Policy/Certificate Holder:

According to our records, you will meet the minimum benefit duration requirement of your four-year New York State Partnership for Long Term Care Insurance policy/certificate (i.e., 1,460 days of nursing home care, home and community-based care, and/or a residential facility care and other required benefits or permissible alternative benefits) within approximately 90 days of continued benefit use. At that time, you may qualify for Medicaid Extended Coverage under the Partnership. As a Qualifying Partnership Policy/Certificate Holder (QPP) under this program, you can apply for Medicaid Extended Coverage for your continuing long-term care needs without regard to your assets.

To apply for Medicaid Extended Coverage, you must contact the Local Department of Social Services (LDSS) in the county where you reside. If you are residing in a nursing home or an adult residential care facility, your county of residence for Medicaid purposes should, in most instances, be the county where you were residing prior to your admission. The LDSS is responsible for conducting the Medicaid Extended Coverage eligibility process.

To facilitate the transition in payer sources for your care from private insurance benefits to Medicaid Extended Coverage, you are encouraged to contact your LDSS and initiate the Medicaid Extended Coverage application process as soon as possible. The telephone number of the appropriate LDSS office appears in the blue pages of your telephone directory under County Government, Department of Social Services.

This notice will serve as verification to the LDSS that you are expected to attain QPP status within 90 days. The precise date on which Medicaid funding may commence will depend on:

- the date you apply for Medicaid Extended Coverage;

- the date on which you exhaust four years (1,460 days) of nursing home care, home and community-based care, and/or residential facility care and other required benefits or permissible alternative benefits; and
- whether you are found otherwise eligible for Medicaid; for example, whether you are income-eligible for Medicaid.

The approximate date when you will meet the minimum benefit duration requirement of your New York State Partnership Long Term Care Insurance policy/certificate is listed below. You will need to provide this letter to your LDSS to verify your QPP status. In addition, as part of the Medicaid Extended Coverage application process, the LDSS will request that you provide information pertaining to your financial status, particularly your income. While assets are exempt from consideration in determining Medicaid Extended Coverage eligibility, the LDSS will ask you to document your assets to the extent that they produce income.

Policy/Certificate Holder:
SSN:
Date of 90-Day Notice:
Approximate date of satisfying minimum benefit duration requirement:
Approximate number of benefit days available before policy/certificate benefits are exhausted:
Insurer Toll-Free Telephone Number for inquiries:

90-DAY NOTICE OF QUALIFYING STATUS FOR MEDICAID EXTENDED COVERAGE

Date of Report/Notice:
Policy/Certificate Holder:
SSN:
Policy/Certificate #:

Dear :

Because you are a Participating Consumer in the New York State Partnership for Long-Term Care program, we are sending you this notice to inform you that, with continued benefit use, you will meet the minimum durational requirement for Medicaid Extended Coverage in approximately 90 days. This means that when you apply for Medicaid, Medicaid will exempt an amount of your assets equivalent to the dollar amount of benefits you received under your Partnership long term care insurance policy. This amount of assets will not be subject to Medicaid's usual transfer and spend down rules, and will not be subject to a Medicaid lien or recovery. You should provide a copy of this notice to your local Department of Social Services when you apply for Medicaid Extended Coverage.

Medicaid will disregard the dollar amount of long term care insurance benefits you have received up until the time you are found eligible for Medicaid Extended Coverage. The higher the dollar amount of benefits received under your insurance policy, the higher the amount of your assets that will be protected when you apply for Medicaid Extended Coverage. Therefore, if you still have coverage remaining under your policy at the point that you are eligible to apply for Medicaid Extended Coverage, you may want to delay applying for Medicaid Extended Coverage until you have used more benefits under your policy. On the other hand, if you will be exhausting the benefits available under your Partnership policy at the same time you meet the minimum durational requirement for Medicaid Extended Coverage, you should apply for Medicaid right away to ensure a smooth transition from private insurance coverage to Medicaid.

The number of additional benefit days that must be used under your Partnership policy to qualify for Medicaid Extended Coverage is indicated below, along with other important information that will help you decide when to submit an application for Medicaid Extended Coverage.

- Approximate date of satisfying minimum benefit duration requirement:

  _____

- Total Dollar Amount of Insurance Benefits Received To Date for Qualified Long Term Care Services:

  $_____

- Approximate Dollar Amount of Additional Insurance Benefits Available Under the Policy for Qualified Long Term Care Services:

  $_____

- Approximate number of benefit days available before policy/certificate benefits are exhausted:

  _____

At the point you have exhausted all of the benefits under your Partnership policy/certificate, we will send you a "Notice of Exhaustion of Policy/Certificate Benefits" that will indicate the final, total amount of insurance benefits paid on your behalf for qualified long-term care services. You should give a copy of this notice to the local Department of Social Services (LDSS) where you apply for Medicaid Extended Coverage.

When you are ready to apply for Medicaid Extended Coverage, you should contact the LDSS in the county where you reside. However, if you are residing in a nursing home or an adult residential care facility, you should contact the LDSS in the county where you were residing prior to your admission. The telephone number of the appropriate LDSS office can be found in the blue pages of your telephone directory under County Government, Department of Social Services. If you live outside New York, please call the New York State Medicaid helpline with questions you may have about Medicaid Extended Coverage at (518) 486-9057.

If you have any questions about this report, please write or call us at [*toll free number of insurer here*]. If you have any questions about the MEC application or eligibility process, please call your LDSS or the Medicaid helpline.

Attachment V
1.5/3/50 and 2/2/100 Plans

Cumulative Report of Benefit Usage

(space for policyholder's or designee's name and address)

Date of Report:
Policy/Certificate Holder:
SSN:
Policy/Certificate #:
Quarter Reported: (MM/DD/YYYY to MM/DD/YYYY)

Dear :

Because you are a participating consumer in the New York State Partnership for Long-Term Care (NYSPLTC) program, we are providing you with this summary of benefits paid to date under your Partnership policy/certificate for qualified long-term care services. Amounts paid for qualified long-term care services are used to determine the amount of your protected assets for purposes of Medicaid Extended Coverage under the NYSPLTC.

- Total Dollar Amount of Insurance Benefits Received to Date for Qualified Long-Term Care Services:

  $_____

- Approximate Dollar Amount of Additional Insurance Benefits Available Under the Policy for Qualified Long-Term Care Services:

  $_____

If you have any questions about this report, please write or call us at [*toll free number of insurer here*].

Attachment VI
1.5/3/50 and 2/2/100 Plans

FINAL POLICY/CERTIFICATE BENEFIT REPORT:

(space for policyholder's or designee's name and address)

Date of Report:
Policy/Certificate Holder:
SSN:
Policy/Certificate #:
Date of Benefit Exhaustion or Policy/Certificate Cancellation:

Dear :

Because you are a participating consumer in the New York State Partnership for Long-Term Care (NYSPLTC) program, we are sending you this report to inform you of the final, total amount of insurance benefits paid on your behalf under your policy/certificate coverage for qualified long-term care services. Because this figure will be used in determining the amount of your protected assets under Medicaid Extended Coverage, you should give a copy of this report to the local Department of Social Services (LDSS) office where you applied or will apply for Medicaid Extended Coverage under the New York State Partnership for Long Term Care program.

- Final, Total Amount of Benefits Paid for Qualified Long-Term Care Services:

$_____

This report represents the last correspondence you will receive form us regarding your benefit payments as they pertain to Medicaid Extended Coverage.

If you have any questions about the information in this report or about your policy/certificate coverage, please write or call us at [*toll free number of insurer here*]. If you have any questions about your application or eligibility for Medicaid Extended Coverage in New York, please call your LDSS office listed in the blue pages of your telephone directory under County Government, Department of Social Services. If you live outside New York and need information or assistance about Medicaid Extended Coverage, please call the New York State Medicaid helpline at (518)486-9057.