TO: Local District Commissioners, Medicaid Directors

FROM: Judith Arnold, Director
Division of Coverage and Enrollment

SUBJECT: Transfer of Assets – Beginning of Increased Look-Back Period, and Coverage Code Changes for Waiver Services

EFFECTIVE DATE: Immediately

CONTACT PERSON: Local District Support:
Upstate (518) 474-8887 NYC (212) 417-4500

The purpose of this GIS message is to update social services districts on a number of changes relating to the transfer of assets provisions. These changes include the increase in the look-back period from 36 to 60 months beginning March 1, 2009, and the completion of the edit changes to Coverage Codes 19 and 21 to allow payment for waiver services.

Look-Back Period

Administrative Directive 05 OMM/ADM-6 advised that the Deficit Reduction Act of 2005 (DRA) required an increase (from 36 months up to 60 months) in the transfer of assets look-back period for all transfers made on or after February 8, 2006. Beginning March 1, 2009, the look-back period increases to 37 months and continues to increase monthly by one-month increments until February 2011, when the full 60-month look-back will be in place for all transfers of assets.

The following manual forms/notices have been revised to address the increase in the look-back period, and are available on the Department of Health (DOH) intranet website:

- DOH-4319 (Rev.3/09) “Long-Term Care Change in Need Resource Checklist” (Attachment I)
- LDSS-4369 (Rev.3/09) “Bank Inquiry and Clearance Report Medicaid/Family Health Plus Only” (Attachment II)
- LDSS-4489 (Rev.3/09) “Notice of Acceptance of Your Medical Assistance Application (Community Coverage With Community-Based Long-Term Care)” (Attachment III)

The following forms, previously made available as attachments to either an ADM or an INF, are revised and can now be accessed on the DOH intranet website:

- OHIP-0020 (Rev. 3/09) “Request For Medicaid Coverage” (Attachment I to 05 OMM/INF-2), (Attachment IV to this GIS)

- OHIP-0021 (Rev. 3/09) "Long-Term Care Documentation Requirement Checklist" (Attachment IV to 04 OMM/ADM-6 (Revised as Attachment II to 06 OMM/ADM-5)), (Attachment V to this GIS)

- OHIP-0022 (Rev. 3/09) "Explanation of the Income and Resource Documentation Requirements for Medicaid" (Attachment I to 04 OMM/ADM-6 (Revised as Attachment IV to 08 OHIP/ADM-4)), (Attachment VI to this GIS)

Changes concerning the increased look-back period have also been made to appropriate Client Notice System (CNS) notices. The February 2009 WMS Coordinator Letter advises of the CNS notices affected by this change.

Effective March 1, 2009, social services districts must ensure all form/notices reflect the correct look-back language.

Medicaid Payment of Waiver Services

Social services districts were advised in GIS 07 MA/018 that the transfer of assets provisions do not apply to individuals applying for or receiving coverage for HCBS waiver services. The GIS further advised districts to continue to authorize Coverage Code 01 (Full Coverage) or 02 (Outpatient Only Coverage) to otherwise eligible waiver participants pending necessary edit changes to Coverage Code 19 (Community Coverage With Community-Based Long-Term Care) and Coverage Code 21 (Outpatient Coverage With Community-Based Long-Term Care) to allow payment of waiver services. Additionally, the continued use of RVI (Resource Verification Indicator) 1 (Current Resource and Previous 36/60 Months) was necessary even though the individual was only required to provide current resource documentation. GIS 08 MA/019 informed districts of the notices that were revised to support this policy change. Districts are advised that the anticipated edit changes to Coverage Codes 19 and 21, needed to allow payment of waiver services, are complete.

Effective for applications filed on or after February 1, 2009, districts should authorize Coverage Code 19 or Coverage Code 21 to otherwise eligible individuals applying for, or requesting an increase in coverage for services provided in a waiver program. The RVI value of 2 (Current Resources) must be used to indicate that resource documentation was provided for the eligibility determination. Waiver participants who were notified of eligibility for Community Coverage with Community-Based Long-Term Care, but authorized Full Coverage/Outpatient Only Coverage on WMS pending the edit changes, can be updated to Coverage Code 19 or 21, as appropriate, at next recertification. Waiver participants who were notified of Medicaid eligibility for all covered care and services will continue to be authorized with such coverage until there is a change in eligibility.

The "Long-Term Care Services" chart (Attachment VII), previously made available as an attachment to 04 OMM/ADM-6, has been updated to include waiver services as services covered under community-based long-term care. The revised form is now available and identified on the intranet as OHIP-0023 (Rev. 3/09).

Long-Term Care Change in Need Resource Checklist

Resources	No	Yes	Amount	
Checking accounts?				Copy of Bank or Credit Union Statements
Savings accounts?				Copy of Bank or Credit Union Statements
Retirement accounts (Deferred Compensation, IRA and/or Keogh)?				Copy of Financial Statements
Life insurance policies?				Copy of Policy and current Statement identifying Face Value and current Cash Value
Stocks, bonds or certificates of deposit (CDs)?				Copy of Stocks, Bonds, Certificates **OR** Copy of Financial Statement
Mutual funds?				Copy of Bonds
Homestead?				Verification of equity interest, if no spouse, minor child or certified blind or certified disabled child resides in the home
Other Real Property including income producing and non-income-producing property?				Copy of Deed and proof of current Fair Market Value
Annuities?				Copy of Annuity Contract/Agreement
"In trust" accounts?				Copy of Financial Statement
Safe Deposit Box?				Copy of Bank Record
Resources other than those listed above?				

Have you or your spouse given away any cash, income or resources, or sold/transferred any real or personal property in the past 60 months?
If yes, when? _____

Have you or your spouse created a trust since your last recertification or transferred any assets to or from a trust, or become a beneficiary of a trust?
If yes, when? _____

If you own your home and no spouse, minor child or certified blind or certified disabled child is residing in the home, is there a legal impediment that prevents you from being able to access your equity interest in the property? If yes, what is the legal impediment? _____

I swear and/or affirm under penalties of perjury that the information I have given regarding my determination for Medicaid coverage for all care and services is correct.

_____ _____ _____ _____

Recipient/Representative Signature **Date Signed** **Spouse/Representative Signature** **Date Signed**

LDSS-4369 (3/09)

BANK INQUIRY AND CLEARANCE REPORT MEDICAID/FAMILY HEALTH PLUS ONLY

Attachment II

TO:	FROM:

On the reverse side of this form we have listed the names, social security numbers and date of birth of individuals applying for or receiving Medicaid/Family Health Plus. When available we have listed account numbers. Please complete and/or provide all information concerning any assets these individuals may have at your institution. **Include information on accounts closed within the last 60 months.**

THE CLIENT HAS GIVEN FULL CONSENT FOR THE RELEASE OF THIS INFORMATION, WHEN APPLYING FOR BENEFITS, PER THE PRIVACY ACT.

This request is made pursuant to Article 1, Section 4 of the N.Y.S. Banking Law and Section 144-a of Social Services Law. This section requires all banking organizations to furnish information to authorized representatives of the local department of social services when the subject of the request is an applicant for or recipient of any assistance, care or services authorized by the Social Services Law.

If you have any questions, please phone the number listed below.

CLIENT'S NAME AND ADDRESS	PREVIOUS ADDRESS

ADDITIONAL INFORMATION

UNIT/WORKER/OFFICE	CASE NUMBER	CASE NAME

SOCIAL SERVICES REPRESENTATIVE SIGNATURE	TITLE	TELEPHONE NO.	DATE SIGNED

COMPLETE REVERSE SIDE

LDSS-4369 (3/09) Reverse

NAME (Last, First, M.I.)	SOCIAL SECURITY #	DATE OF BIRTH	NO RECORD	ACCOUNT NO.	TYPE	INTEREST RATE	JOINT	DATE OPEN	☐ IF CLOSED LAST W/DRAWAL		BALANCE	
									DATE	AMOUNT	DATE	AMOUNT

Do any of the individuals listed have any of the following? If so, specify owner and nature of accounts.

☐ Bank Loan (Specify): _____

☐ Safe Deposit Box (Specify): _____

☐ Direct Deposit of Payroll/Government Check (Source): _____ (Amount): _____ (Time Period): _____

☐ Other Bank Investment Services (Specify): _____

ADDITIONAL INFORMATION:

BANK ORGANIZATION REPRESENTATIVE SIGNATURE	TITLE	TELEPHONE NO.	DATE SENT
X			

Please Return This Form

THANK YOU FOR YOUR COOPERATON

LDSS-4489 (3/09)

NOTICE OF ACCEPTANCE OF YOUR MEDICAL ASSISTANCE APPLICATION (Community Coverage With Community Based Long Term Care)

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		
		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____ **OR** Agency Conference _____ Fair Hearing Information and Assistance _____ Record Access _____ Legal Assistance Information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

We are sending this notice to tell you that this Department will **ACCEPT** your Medical Assistance application dated _____ for name(s) _____ for Community Medicaid Coverage With Community-Based Long Term Care. The reason for this decision follows:

- ❑ Since you requested that we determine your Medicaid eligibility for all covered care and services including community-based long term care but not nursing facility services, we did not review proof of your resources for the transfer of assets look-back period (up to 60 months prior to your request) and you will **NOT** be covered for the following nursing facility services:
  - nursing home care other than short term rehabilitation
  - nursing home care provided in a hospital
  - hospice in a nursing home
  - managed long term care in a nursing home
  - intermediate care facility services
- ❑ You requested that we determine your Medicaid eligibility for all covered care and services including nursing facility services but you did not provide proof of your resources for the transfer of assets look-back period (up to 60 months prior to your request). You failed to verify:

  _____

  _____.

  Since you did not provide proof of your resources for the transfer of assets look-back period (up to 60 months), you will not be covered for the nursing facility services listed above.
- ❑ **EXCESS INCOME/RESOURCES**
  See the enclosed LDSS-3973: Notice of Decision on Your Medical Assistance Application (Excess Income/Resources).

  NOTE: If there are other factors that affect your Medical Assistance Coverage, a separate notice is enclosed.

Please review the Medical Assistance Utilization Threshold information, found in the Medical Assistance section of the booklet, "LDSS-4148B: What You Should Know About Social Services Programs." The information explains any services limitations. The LDSS-4148B was given to you when you applied for assistance.

If you submitted paid medical bills for direct reimbursement, you will be notified separately of our decision.

If you need Medicaid coverage of nursing facility services, contact your worker immediately. We will then arrange to review proof of your resources for the transfer of assets look-back period to find out if you are eligible for Medicaid coverage for these services.

The law and/or regulation(s) which allow us to do this are Social Services Law 366-a(2) and 18 NYCRR 360-2.3, 360-4.1, 360-4.4, 360-4.5, 360-4.7, 360-4.8.

We have enclosed a budget worksheet(s) so that you can see how we determined eligibility for benefits.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

LDSS-4489 (3/09) Reverse

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the front page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

1) **Telephone:** You may call the state wide toll free number: 800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**

2) **Fax:** Send a copy of this notice to fax no. (518) 473-6735. **OR**

3) **On-Line:** Complete and send the online request form at: **https://www.otda.state.ny.us/oah/forms.asp. OR**

4) **Write:** Send a copy of this notice **completed**, to the Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:_____

_____

_____

Print Name: _____ Case Number_____

Address: _____Telephone: _____

Signature of Client: _____ Date: _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the front of this notice.

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file which we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file which you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of the front of this notice or write us at the address printed at the top of the front of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of the front of this notice or write to us at the address printed at the top of the front of this notice.

ATTENTION: Children under 19 years of age who are not eligible for Child Health Plus A or other health insurance may be eligible for the Child Health Plus B Insurance Plan (Child Health Plus B). The plan provides health care insurance for children. Call 1-800-522-5006 for information.

OHIP-0020 (Rev. 3/09)

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 Income and 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 an increase in Medicaid coverage for Long-Term Care Services. If I need nursing facility services, I must give proof of my resources for up to 60 months 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.

If I need nursing facility services, I must request an increase in Medicaid coverage and I must give proof of my resources for up to 60 months prior to my request for such services.

Determine my Medicaid eligibility for all covered care and services (you must be in receipt of nursing facility services).

I understand that I must give proof of my resources for the transfer of assets look-back period (up to 60 months 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.

OHIP-0021 (Rev. 3/09)

LDSS NAME
LETTERHEAD

Date _____

Long-Term Care Documentation Requirement Checklist

Case Name: _____ Representative Name: _____
Address: _____ Due Date: _____
_____ Case Number: _____

On _____, you requested Medicaid coverage of long-term care services. In order for us to determine your eligibility for long-term care services, including up to three months prior to the month of your request, your worker must receive the following information checked below no later than the above due date. Failure to submit the information may result in the denial of Medical Assistance coverage for long-term care services. If you cannot obtain these items by the above due date, you must contact your worker to request a brief extension. Verification of your attempt to obtain these documents may be required prior to granting an extension.

☐ You are requesting we (re)determine your eligibility for undue hardship for Medicaid coverage of nursing facility services. Undue hardship exists when you meet all other eligibility requirements, and are not able to obtain appropriate medical care such that your health or life is in danger or the application of the transfer penalty period would deprive you of food, clothing, shelter or other necessities of life. You must provide proof of how you meet undue hardship.

☐ Complete, sign and return the enclosed "Long-Term Care Change In Need Resource Checklist." You must provide proof of the value of each resource checked "Yes" for the period _____ to_____.

□ Document all checks and withdrawals over $ _____

□ Copies of your income tax returns (including 1099s and all schedules and forms) for the year(s) _____

□ Additional documentation: _____

_____

_____ _____
Social Welfare Examiner Phone Number

EXPLANATION OF THE INCOME AND RESOURCE DOCUMENTATION REQUIREMENTS FOR MEDICAID

In order to be eligible for Medicaid coverage of certain care and services, you must submit proof of your income and resources. The following explains the information that must be submitted in order to be eligible for coverage of certain care and services.

When you apply for Medicaid, you will be asked to choose one of the following:

1. community coverage **without** long-term care;

2. community coverage with community-based long-term care; or

3. Medicaid coverage for **all** covered care and services.

Note:

- If you are applying for Medicaid coverage for all covered care and services, you must be in receipt of nursing facility services (see #3 below) in order for eligibility to be determined for this level of care.

- Pregnant women, children under age one, and children between the ages of one and 19, who have incomes at or below the applicable federal poverty level, do not need to provide proof of their resources in order to qualify for Medicaid coverage for all care and services; they do, however, need to submit proof of income.

1. Community Coverage Without Long-Term Care

Applicants/recipients who do **not** need nursing facility services or community-based long-term care must submit proof of income and may attest to the amount of their resources. At renewal you may also attest to the amount of your income. If we find that you are eligible under this simplified review, you will get Medicaid coverage but **not** coverage for nursing facility services or community-based long-term care. If at some time you need nursing facility or community-based long-term care services, we will need to look at your income and resources before Medicaid can cover these services.

People who attest to the amount of their income and resources are eligible for short-term rehabilitation services. Short-term rehabilitation includes one commencement/admission in a 12-month period of up to 29 consecutive days of nursing home care and certified home health care.

If we find the information you report is different from the information we get from investigating what you reported, you will be requested to give us proof of your income and resources.

2. Community Coverage With Community-Based Long-Term Care Includes:

- Adult day health care
- Limited licensed home care
- Certified Home Health Agency Services
- Hospice in the community
- Hospice residence program
- Personal care services
- Personal emergency response services
- Private duty nursing
- Residential treatment facility
- Consumer directed personal assistance program
- Assisted living program
- Managed long-term care in the community
- Waiver and other services provided through a home and community-based waiver program

To be eligible for community coverage **with** community-based long-term care services, you must give us proof of your current income and resources. If we find that you are eligible, you will get Medicaid covered care and services that include community-based long-term care services, but**,** you will **not** get coverage for nursing facility services, except for short-term rehabilitation. If you later need nursing facility services, you must request an increase in your Medicaid coverage. We will need to review documentation of your resources for the transfer of assets look-back period (up to 60 months prior to the first month for which you are seeking Medicaid for payment of nursing facility services (see #3 below)).

3. Medicaid Coverage for All Covered Care and Services Includes the Following Nursing Facility Services:

- Nursing home care
- Nursing home care provided in a hospital
- Hospice in a nursing home
- Managed long-term care in a nursing home
- Intermediate care facility services

To be eligible for these services, you must submit proof of your income and, we must review documentation of your resources for up to 60 months prior to the first month for which you are seeking Medicaid payment of nursing facility services. If we find that you are eligible, you will get **all** Medicaid covered care and services including the nursing facility services listed above and the community-based long-term care services listed under #2 above.

Applicants/recipients who are not receiving nursing facility services now may only apply for Community Coverage with Community-Based Long-Term Care (#2 above) or Community Coverage **without** Long-Term Care (#1 above).

If you become in need of a service for which you have not received coverage, contact your worker immediately for assistance.

LONG-TERM CARE SERVICES

LONG-TERM CARE		
Community-Based Long-Term Care Services	**Nursing Facility Services**	**Short-Term Rehabilitation Services**
- Adult day health care - Assisted living program (ALP) - Certified home health agency (CHHA) - Hospice in the community - Hospice residence program - Residential treatment facility - Managed long-term care in the community - Personal care services - Waiver and non-waiver services provided in the following programs: a) Long-Term Home Health Care Program b) Traumatic Brain Injury Waiver Program c) Care at Home Waiver Program d) Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program e) Nursing Home Transition and Diversion Home and Community Based Services Waiver Program - Consumer directed personal assistance program - Limited licensed home care services - Personal emergency response services - Private duty nursing	- Alternate level of care provided in a hospital - Hospice in a nursing home - Nursing home care - Intermediate care facility - Managed long-term care in a nursing home	One commencement/admission in a 12-month period of up to 29 consecutive days of : - Nursing home care - Certified home health care