NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES
40 NORTH PEARL STREET, ALBANY, NEW YORK 12243

...R A. PERALES
...mmissioner

[An Administrative Directive is a written communication to local Social Services Districts providing directions to be followed in the administration of public assistance and care programs.]

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL NO.: 87 ADM-4
(Medical Assistance)

TO: All Local Commissioners

SUBJECT: Excess Income Program Information and Administrative Controls

DATE: February 20, 1987

SUGGESTED DISTRIBUTION:

Medical Assistance Staff
Income Maintenance Staff
Fair Hearing Staff
Accounting Staff
Staff Development Coordinators

CONTACT PERSON:

Questions concerning Medical Assistance eligibility should be directed to your County Representative by calling 1-800-342-3715, extention 3-7581, or (212) 488-7581 in New York City.

I. PURPOSE

The purpose of this Directive, is as follows:

A) To provide local districts with a standardized informational letter to be given to applicants/recipients of Medical Assistance which explains the eligibility requirements of the excess income (surplus/spenddown) portion of the program

B) To provide a revised version of DSS-3183 "Provider/Recipient Report (Financial Obligation of Recipient Toward Medical Care)", a form designed to provide a clear explanation and listing to both Medical Assistance providers and Medical Assistance recipients of the specific outstanding medical bills used to meet the spenddown obligation in excess income cases, and,

C) To provide instructions regarding the appropriate application of medical bills toward meeting the spenddown.

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Social Services Law and Other Legal References	Bulletin/Chapter Reference	Miscellaneous Reference
84 ADM-41 83 ADM-72		360.17(a)(14) 360.5(d) 300.15	SSL§ 20 34 366.2(b)		MARG pp 223-231 Code Cards p 5 42 CFR 435.831

(REV. 8/82)

II. BACKGROUND

A) In issuing 84 ADM-41 "Standardized MA-Only Notices", the Department required all districts to utilize state designed letters to notify applicants/recipients of certain case actions. Districts were instructed to notify applicants for Medical Assistance of the agency's decision regarding the application as well as to notify recipients of changes or intent to discontinue Medical Assistance coverage.

The letter contained in this release entitled "Explanation of the Excess Income Program" (See Attachment I) was developed to explain to applicants/recipients (A/Rs) that they may become eligible for Medical Assistance by providing documentation to the local district which confirms sufficient allowable medical expenses to offset an income overage. The letter also lists types of medical expenses which the A/R may present in order to meet spenddown requirements. This letter has been prepared in conjunction with representatives of local departments of social services and legal groups in both upstate and downstate New York based upon a compilation of ideas presented in various locally issued letters.

B) Currently, there is no requirement except in hospital cases that the provider receive notification concerning the recipient's spenddown obligation. Therefore, the recipient, who may not have a clear understanding of his responsibility, is left with the further responsibility of notifying the provider of his obligation. The DSS-3183, a form which may be sent to the provider by the LDSS (advising the provider of the client's liability - see Attachment #2) has been in use in a number of local social services districts. With this release it is being revised to provide a clearer understanding of recipient liability and provider responsibility to both the provider and the recipient.

C) The overpayment of medical bills by excess income recipients has often caused administrative problems when establishing eligibility in excess income cases. Certain other problems exist as well in regard to bills from non-Medicaid providers, those medical providers who have chosen not to accept Medical Assistance payments and for bills for non-covered services. Confusion has sometimes resulted from the interaction of numerous variables, for example, date of bill, type of provider, type of service and private versus MA rate. Guidelines have been developed to more clearly present the administrative options available to districts when applying medical bills toward a spenddown.

III. PROGRAM IMPLICATIONS

A) Whenever spenddown is indicated, local districts shall include a copy of the Explanation of the Excess Income Program letter along with the notice the A/R receives of acceptance, change, denial or discontinuance.

The letter may be reproduced on local agency letterhead, but the contents shall not be changed by the district. Local districts may also include, additional information as would be appropriate and beneficial for local administration of the program. However, any such additional information must first be approved by the Department pursuant to Social Services Law 20 and 34.

B) Form DSS-3183 has been redesigned to explain Excess Income Program requirements and to provide a clear written statement of (1) the financial responsibility of the recipient as well as (2) the billing responsibility of the provider. Use of this form for spenddown cases will reduce the potential for both billing and eligibility errors.

C) Guidelines have been developed which describe a number of administrative options available for processing bills presented for use in spenddown cases. For ease of understanding, these guidelines are presented in outline format and have been divided by timeframe (pre-retroactive, retroactive, concurrent and prospective), as well as status (paid versus incurred and Medicaid-covered versus non-covered).

IV. REQUIRED ACTION

A) Upon receipt of this directive, the district shall include, along with the initial notice to the applicant of a decision which indicates a spenddown liability, a copy of the attached "Explanation of the Excess Income Program". The district shall also include this letter with the notice to the recipient whenever an intended change, denial or discontinuation of Medical Assistance indicates a spenddown liability situation.

In addition to the above, this notice shall also be made available as public information and, therefore, provided to all interested parties upon request.

B) With the release of this directive, districts shall include with each acceptance notice, redetermination or appropriate change in which an incurred medical bill is used to achieve eligibility, a copy of the revised DSS-3183. This is being done in order to advise both the client and the provider of the client's specific liability towards that provider's bill.

In many spenddown cases, the agency will only need to use bills from one provider to meet the recipient's excess income amount. In such cases, only one DSS-3183 form will need to be completed. Designated copies should be sent to the provider, the recipient and, in accordance with local agency procedures, to the accounting/audit unit. A copy should also be kept in the case record to provide an audit trail and to assist in future eligibility determinations.

In situations where bills from two or more providers are required to meet the excess, it will be necessary to use a separate form for each provider. This is being done to protect the client's confidentiality. Without a specific medical release signed by the client, the agency may not reveal (to another provider) the details of medical services or supplies the recipient has received. Therefore, a separate form for each provider must be completed and a copy of each sent to the recipient.

Use of the revised DSS-3183 is being mandated at this time in all spenddown cases so that the agency can clearly and officially advise the provider of case specific billing limitations (as well as formally advising the recipient of his/her specific liability requirements). Any inappropriate billing by the providers could then be followed by administrative recovery or legal action.

C) Districts are to use the following guidelines in applying medical bills toward a spenddown. While perhaps not all-inclusive, these guidelines are nevertheless designed to provide a framework of basic administrative options for numerous types of spenddown bill situations. When a combination of bills is presented, the agency should use its judgment in selecting the most appropriate alternatives in order to satisfy program requirements.

When presented to the agency, bills which are not payable by the program such as paid bills, non-covered services (e.g. chiropractic) and non-participating providers, should be used toward meeting the spenddown before using bills which are payable (e.g., incurred bills for covered services from participating providers). As well, medical expenses from a legally responsible relative whose income is considered available to the applicant should be used in reducing the spenddown. Such bills, which are not payable by the program, would be considered prior to using the applicant's incurred expenses.

1. Bills for Services Predating The Retroactive Period

(also called "older" or pre-retroactive bills - those bills for medical services received prior to three months preceding the month of application).

a) Status: Paid (prior to retroactive period)

Action: None.

Options: None.

Rationale: Bills which were paid prior to the retroactive period cannot be counted toward the current spenddown since the A/R's current liability is not affected by such payments, nor were the A/R's needs at the time of payment evaluated against such expenses.

b) Status: Unpaid (when presented to the district).

Action: May be used in spenddown ONLY if still viable, that is if the provider is still seeking payment. Note: this must be verified before the bill is applied toward the spenddown.

Options: Viable "older" unpaid bills shall be applied toward a current spenddown for a period of up to six months at a time. For bills which exceed six months of liability, additional periods of up to six months at a time may be authorized on any remaining balance of the bill(s) not previously applied toward a spenddown (so long as that bill continues to be viable).

Viable "older" unpaid medical bills should be applied toward the spenddown prior to the application of more recent unpaid medical bills (incurred during the retroactive or current period).

On the other hand, viable "older" unpaid bills should be applied toward the spenddown after the application of medical bills which were paid during the retroactive or current period (when determining eligibility for months in which a bill was paid).

Viable older medical bills should be applied starting with the retroactive period if the client had an income overage during that time and had received medical services coverable by the program.

Rationale: Current federal regulations do not limit the age of unpaid medical bills. The only requirement for the application of medical expenses toward a spenddown is that a liability currently exist for a medical expense. The policy remains that of honoring currently viable unpaid medical expenses.

Use of older medical bills prior to the use of current unpaid medical bills is seen as more beneficial to the A/R since we may be able to pay current and retroactive bills but not "older" ones.

Application of older bills beginning with the retroactive period as specified above is in keeping with existent federal requirements.

2. Bills for Services Received During The Retroactive Period.

Those bills for medical services received during the three months preceding the month of application.

a) Status: Paid (during retroactive period).

Action: Must be applied toward the spenddown beginning with the month in which the payment was made or when service was given.

Options: When a client pays for medical expenses in excess of the amount of the monthly spenddown, credit may be given in the following manner:

i) additional months of appropriate coverage shall be authorized equal to multiples of the spenddown for a period of up to six months at a time, for example a client who has a $25.00 monthly overage and pays a medical bill for $100.00 may be given four (4) months of outpatient coverage beginning with the month of service (that is the month in which the medical expense was

incurred) or the month of payment if the client had other medical services coverable by the program.

ii) the client may also seek to receive a refund from the provider of that portion of the payment which exceeds the necessary spenddown amount. In the example above, a client with a $25.00 overage who only wishes one month of coverage may seek a refund of $75.00 from the provider. The provider could then bill for the appropriate balance through MMIS. We note however, that at present there is no authority to require a refund from the provider under these circumstances.

Rationale: Medical Assistance is a program which pays enrolled providers for medical care and services. A client is required to offset only one month of income overage in order to achieve eligibility for outpatient coverage (for that month). There is no requirement for a client to assume responsibility for any more of a bill(s) than an amount equal to the monthly spenddown (or six months if full coverage is being sought). While a client may be encouraged to assume responsibility for only that amount of medical expenses which is necessary to achieve eligibility, a mechanism must exist to deal reasonably with situations in which a client nevertheless exceeds the fiscal requirements for eligibility.

b) Status: Unpaid (during retroactive period).

Action: Applied toward spenddown.

Options: Begin with month of service so long as client has a need to establish eligibility beginning in the retroactive period.

Rationale: In accordance with federal requirements, whenever a client has other outstanding medical expenses which may be paid by the Medical Assistance program during the retroactive period, then eligibility should be established beginning as early in the retroactive period as possible.

3. Bills for Services Received During The Application Period (that period following submission of an application and prior to date of determination).

a) Status: Paid (pending outcome of decision on eligibility).

Action: Must be applied toward the spenddown.

Options: Same as in 2 a) above

Rationale: Same as in 2 a) above

Please note:

(i) The local agency should advise the applicant to attempt to avoid unnecessary personal payment of bills (excessive payment to Medicaid providers) prior to receiving the results of the agency's determination.

(ii) Bills which are paid by the client because of an agency error such as miscalculation of liability or delay of determination, shall be reimbursed as authorized by Departmental Regulation 360.17(a)(4). An update to 83 ADM-72 dealing with this issue is currently being prepared by this Department's Office of Financial Management.

b) Status: Unpaid.

Action: Applied toward spenddown.

Options: For a "split" bill, the client is liable only for that portion of the bill which is necessary to achieve eligibility. The balance of the bill may be paid by the Medical Assistance Program up to the MA fee or rate (as, of course, are the other appropriate, payable medical bills incurred during the eligibility period).

For bills not payable by the program, such as non-Medicaid providers, or non-Medicaid services (e.g., chiropractic) the client should be given credit when necessary in the form of additional months of coverage beyond the application month (with full coverage resulting from incurring a bill(s) equivalent to a six month liability).

Rationale: Client is entitled to credit for all necessary medical care. Use of MA participating providers is necessary only for payment by the program and cannot be mandated for the generation of bills to be used in meeting the spenddown. Since the program cannot pay for such services, the only reasonable option is to allow for credit as described above.

4. Bills Acquired Subsequent To The Onset Of Eligibility.

a) Status: Paid

Action: Must be applied toward the spenddown.

Options: When a client pays for medical expenses in excess of the amount of the monthly spenddown, credit may be given in the following manner:

i) additional months of appropriate coverage may be authorized equal to multiples of the spenddown for a period of up to six months at a time, beginning with the month of payment.

ii) the client may also seek to receive a refund from the provider of that portion of the payment which exceeds the necessary spenddown amount.

Rationale: See 2a for additional details.

b) Status: Unpaid

Action: Applied toward spenddown.

Options: For a "split" bill, the client is liable only for that portion of the bill which is necessary to achieve eligibility.

For bills not payable by the program the client should be given credit when necessary in the form of additional months of coverage.

Rationale: See 3b for additional details

V. WMS IMPLICATIONS

Even though there will not be any changes made to WMS as a result of this Administrative Directive, the primary mechanism for entry of WMS data for MA only one month excess income cases (outpatient coverage) will be reiterated. Six month excess income cases (full coverage) will continue to be entered into Principal Provider Subsystem as is currently done.

When a determination is made that a client may be eligible for outpatient coverage via a spenddown, the case should be authorized as "provisionally eligible" using MA Coverage Code 06 - Provisional Eligibility on WMS Screen 5. When the monthly excess is met, districts should enter eligibility using MA Coverage Code 02 - Outpatient Coverage to authorize payment for outpatient care and services. If the Authorization "To" Date extends beyond the outpatient coverage period, the 06 Coverage Code is returned effective the first day of the month <u>following</u> the outpatient period until the last day of the Authorization "To" Date Month.

Coverage Code 02 may also be entered initially if the excess for the current or prior month(s) has been met. However, if this is done WMS will <u>not</u> automatically return the Coverage Code to 06 - Provisional Eligibility.

Each provisionally eligible case should be reviewed periodically and removed from the file if further activity on the case is not anticipated.

Currently there is no MA subsystem designed to control monthly spenddown amounts. The DSS-3183 and the MBL budget shall continue to serve as documentation of the spenddown amount.

VI. EFFECTIVE DATE

This release is effective March 1, 1987.

Nelson Weinstock
for the
Division of Medical Assistance

ATTACHMENT I

EXPLANATION OF THE EXCESS INCOME PROGRAM

The following is an explanation of how you may become eligible for Medical Assistance and receive help with your medical bills even though your income may be over the limit. Please contact your social services worker if you need help understanding this letter.

If you have applied for Medical Assistance, our written notice to you will tell you if you have income over the Medical Assistance income level and the amount by which your income is over. This amount is also called excess income. If your net income is over (in excess of) the Medical Assistance level for your family size for a period in which you want help with your medical bills, you may receive Medical Assistance coverage only if either of the following conditions are met.

A. Outpatient Care and Service (One Month Eligibility)

You can become eligible for Medical Assistance for outpatient care and services if in any month you have medical bills that are equal to or more than the amount of your excess income.

This is possible under the Excess Income Program which provides outpatient coverage on a month-to-month basis for people who become eligible by bringing us their paid or unpaid medical bills which add up to at least the amount of their monthly excess income. You must present these medical bills to the agency when they add up to at least the amount of your excess income.

When you incur (owe) or have paid the amount of your monthly excess income and have submitted these bills and/or receipts to the agency, you may receive Medical Assistance coverage for all other eligible outpatient services for that month.

OR

B. Outpatient and Inpatient/Hospital Care & Services (Six Month Eligibility)

You can become eligible for Medical Assistance for all appropriate medical care and services (inpatient and outpatient) if you become hospitalized and/or are seeking help with your inpatient hospital bills, and if you incur (owe) or have paid an amount of medical bills equal to your monthly excess income for six months. Once you have medical bills (paid or unpaid), including any other medical bills besides your hospital bill that equal this six months' figure and present them to the agency, you will then receive Medical Assistance coverage each month for these six months for all other covered medical expenses (whether in-hospital or not).

C. Medicare, Private Insurance and Use of Bill

If a bill or service is covered in full by Medicare or private insurance, it cannot count as a medical expense to meet your monthly excess. If only part of a bill is covered by Medicare or private insurance, then that portion which remains (not covered by Medicare or private insurance) can count toward reducing or eliminating your monthly excess.

Bills for your care, your spouse's care if you live with your spouse or your children under 21 may be counted toward your monthly excess within the following guidelines. Medical bills of a child living with you will be considered if the child is included in the case. Medical bills of a child who is not part of your household may also be considered so long as you are providing medical support for the child. Bills for your parents care if you are under 21 and live with your parents may also be counted toward meeting your monthly excess. Unpaid bills from prior months may be counted toward meeting your monthly excess. Once unpaid bills, whether old or current, are credited toward meeting your monthly excess, they cannot be counted again.

After you have enrolled in the Excess Income Program, you must arrange to either bring in or mail in your bills and receipts each month once you have accumulated medical expenses equal to or greater than your excess income.

We suggest that you make any necessary doctors appointments or fill prescriptions in the early part of each month so that, after you have met your excess amount, you can have the benefit of a Medical Assistance card to use for the payment of other medical expenses for that month. Medical Assistance may also be available for unpaid bills for services and supplies received in the three calendar months prior to the month you applied.

D. Payment of Medical Bills

It is important to check to see if your doctor or other medical person accepts Medical Assistance payments. Medical Assistance will only pay bills from a doctor, druggist or other provider who accepts payments under New York's Medical Assistance Program. However, even if the doctor or other medical person does not accept Medical Assistance payments, you may still use bills from that person, whether paid or unpaid, to meet your excess income amount to qualify under the Excess Income Program (See below).

E. Allowable Medical Expenses

You should note that when meeting your excess amount, you can use doctor bills as well as medical expenses such as:

- Transportation expenses to obtain necessary medical services (in most cases).

- Medical expenses or payments made to therapists, nurses, personal care attendants and home health aides (as required by a physician).

- Prescription drug bills.

- Payments made toward surgical supplies, medical equipment, prosthetic devices, hearing aids and eye glasses (as ordered by a doctor).

You can also use medical expenses which are not covered by the Medical Assistance Program such as:

- Chiropractor's service (and other non-covered services).

- Services from non-participating providers (people who provide medical services but do not accept Medical Assistance payments).

- Some over-the-counter drugs and medical supplies such as bandages and dressings may be applied toward reduction of your excess income if they have been ordered by a doctor or are medically necessary. Bills for cosmetics and other non-medical items are not acceptable.

Certain of these bills can be counted only if required by a physician. Some of these services and supplies can also be paid for with your Medical Assistance card, but may have some restrictions.

Should there be a change in your circumstances (financial, household size, etc), your eligibility in the Excess Income Program could be affected. All changes must be reported to your local social services office.

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT YOUR MEDICAL ASSISTANCE ELIGIBILITY EXAMINER FOR DETAILS.

Attachment II

DSS-3183 (7/88)

PROVIDER/RECIPIENT LETTER

(Financial Obligation of Recipient Toward Medical Expenses)

To: (Name/Address of Provider)	Concerning: (Name/Address of Recipient) CIN #_____ (Case# in NYC) _____

This report is to advise **both** the Medical Assistance Provider and the Medical Assistance Recipient of the sharing of certain costs between the recipient and the Department of Social Services (Medical Assistance Program). The Medical Assistance Provider named on this form must take note of all payment exclusions/limitations as noted on this form before billing the Medical Assistance Program for this recipient.

Medical Assistance has been authorized for you, the above named recipient for the month(s) of _____.
This authorization is for:

☐ Outpatient care **only**

☐ all available benefits (Inpatient and Outpatient)

This decision was based on the fact that you as the recipient had income in excess of the eligibility level, as you were advised in your Notice of Decision, and had to incur medical costs at least equal to the amount of this excess to become eligible for Medical Assistance. The unpaid bills which you used to become eligible are listed below. These bills are your responsibility and are **not** to be billed by your medical provider to the Medical Assistance Program.

Provider	Bill Date	Date of Service	Patient's Name	Amount

NOTE TO ELIGIBILITY WORKER:
COMPLETE THE FOLLOWING SECTION ONLY IF APPLICABLE

You as the recipient are responsible for $_____ of the following bill. After deducting this amount from the Medical Assistance rate or fee, the balance, if any, may be billed **by your medical provider** to the Medical Assistance Program.

Provider	Bill Date	Date of Service	Patient's Name	Amount

ELIGIBILITY WORKER'S SIGNATURE	TELEPHONE NO.	DATE
X		

NOTE TO AGENCY RECIPIENT AND PROVIDER:
SEE REVERSE FOR IMPORTANT INFORMATION/INSTRUCTIONS

DSS-3183 (7/86)

PROVIDER PLEASE NOTE: Since the recipient is responsible for the charges or portions thereof as indicated on the front side of this form. billing the Medical Assistance Program for such charges to the recipient without specific authorization from the Department of Social Services would be inappropriate and may constitute a fraudulent act which may result in recovery action and possible criminal prosecution.

RECIPIENT PLEASE NOTE: You will receive a separate form for each medical provider that you used to become eligible. The purpose of this form is to advise you of unpaid medical bills for which you are responsible. These are the unpaid bills which were presented to the Department of Social Services to be used to help you become eligible for the Medical Assistance Program.

A separate copy of each of the forms being sent to you is also being sent to the medical provider so that the provider will be aware of your responsibility for the bills listed on the reverse side of this form. Each provider, when more than one provider is involved, will receive a separate report containing **only** his/her bills. This is being done to guarantee the confidentiality of your medical services.

If you have any questions concerning the information on this form, please call the eligibility worker whose name and phone number appear on the front side of this form.

AGENCY PLEASE NOTE: A separate form **MUST** be completed for each provider detailing only his bill(s) where bills from more than one provider are being used to establish eligibility.