ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 95 ADM-17

DIVISION: Health and Long Term Care

TO: Commissioners of Social Services

DATE: October 6, 1995

SUBJECT: Community Coverage Option

SUGGESTED DISTRIBUTION:	Medical Assistance Staff Fair Hearing Staff Legal Staff QA&A Staff Staff Development Coordinators
CONTACT PERSON:	Upstate: Barbara Crumb, Bureau of Eligibility and Resources, 1-800-343-8859, extension 3-6206 or User ID 0ME140 NYC: Call (212) 383-2512
ATTACHMENTS:	Attachment I Consent for Community Eligibility Determination Attachment II Notice of Decision Community Coverage No Excess Attachment III Notice of Decision Community Coverage Excess Attachment IV Notice of Decision Full Coverage Community Based Attachment V Notice of Intent to Establish a Liability Toward Chronic Care Attachment VI Notice of Decision On Your Medical Assistance Application (Full Coverage)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
(OBRA 93 Trust & Transfer ADM) 89 ADM-45			Chapter 170 Laws of 1994		

DSS-296EL (REV. 9/89)

I. PURPOSE

The purpose of this Administrative Directive (ADM) is to notify social services districts that they may elect to offer certain Medical Assistance (MA) applicants the option of applying for full MA coverage or for community coverage (which includes all MA covered services except nursing facility services). If a social services district elects to provide applicants with this option, it will not be necessary for the district to document transfers of assets during the applicable look-back period for those applicants who are seeking community coverage only.

II. BACKGROUND

Since 1989, persons who have made certain transfers have been ineligible for MA coverage of institutionalized level of care for specified periods of time. Institutionalized level of care includes:

- nursing facility services provided in hospitals, residential health care facilities, residential treatment facilities or intermediate care facilities for the developmentally disabled, or;

- care, services or supplies furnished pursuant to a waiver under Section 1915 (c) or (d) of the Social Security Act including: the long term home health care program, the OMRDD home and community based services waiver, the Traumatic Brain Injury waiver or the Care at Home Program.

This requirement has resulted in the need to review resources for a look-back period of up to thirty months prior to the date of application for Medical Assistance (MA) to ensure that there were no disqualifying transfers that would effect a person's eligibility for full coverage. With the passage of the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), as implemented by Chapter 170 of the Laws of 1994, social services districts are now required to evaluate any transfers made in the past 36 months, or trusts created in the past 60 months if they were made or created on or after August 11, 1993. With the release of this ADM, districts will be able to redeploy staff by reducing the number of full resource reviews required.

III. PROGRAM IMPLICATIONS

Effective July 1, 1995, social services districts may offer a choice to certain MA applicants for a determination of eligibility for full MA coverage (which includes nursing facility services) or a determination of eligibility for community coverage (which includes all MA covered services except nursing facility services). The former includes an examination of resources during the look-back period, while the latter determination is only based upon current income and resources.

This choice can not be offered to Home Relief (HR) related single individuals and HR-related childless couples. They must continue to meet cash assistance standards. In addition, individuals applying for, or in receipt of, nursing facility services or waivered services as described in Section II can not be offered this option and must have a full review of resources made to determine whether a prohibited transfer has been made during the look-back period. At the present time, the provisions of this directive are to be applied only to the MA-Only population. In order to determine which districts are implementing this option, all social services districts electing to offer this option must contact:

Barbara Crumb
Division of Health & Long Term Care
New York State Department of Social Services
40 N. Pearl St.
Albany, New York 12243

Social services districts are advised that the procedures included herein are to be considered interim procedures only. The Department is in the process of developing the necessary systems changes to support the statewide implementation of the Community Coverage option.

IV. REQUIRED ACTION

When social services districts offer applicants the option of applying for community overage, they must provide all applicants with the information included in Attachment I. The applicant should sign the form, indicating the coverage for which he or she is applying. A copy of the signed form must be maintained in the case record. If the applicant applies for community coverage, the social services district must:

- pursuant to the provisions of 93-ADM 29, document current resources and current and projected income, along with the other non-financial factors of eligibility;

- if the applicant is determined eligible, authorize the case with community coverage only, and notify the applicant using the notices included as Attachments II or III.

If the applicant elects to apply for full coverage, the social services district must continue to follow current procedures. The social services district must complete the full application process, including an appropriate resource review, as of the time that full coverage is requested/required to determine that there has not been a disqualifying transfer within the applicable look-back period.

If a recipient of community coverage requires nursing facility services or requires alternate level of care placement following a period of acute hospitalization, that request shall be considered as a new application, and all regulations pertaining to new applications must be followed. Although the applicant will not be required to submit a new

application form, the social services district will be required to complete the full resource review within the required 30 day time frame,and make a determination of eligibility for full MA coverage. For purposes of the resource review, the look-back period is determined from the first month in which the person both applies for full MA coverage and is institutionalized. Social services districts are reminded that much of the necessary information to complete this review may exist in the case record if the recipient has been active for a number of years with community coverage.

If the applicant is determined eligible for full MA coverage, the worker will compute the budget to determine the NAMI (or, in the case of a person receiving waivered services, the spenddown amount). The NAMI will be effective with the first full month of institutionalization. If the district establishes that a disqualifying transfer has occurred, the worker will compute the appropriate penalty period, and authorize the case according to the procedures established in 89 ADM-45 and Chapter 170 of the Laws of 1994.

V . NOTICE REQUIREMENTS

In social services districts which elect to give MA applicants the choice of applying either for full MA coverage or for community coverage only, all MA applicants must sign and date a statement (Attachment I) indicating which type of coverage they are seeking. A copy of the statement will be given to the applicant and a copy will be retained in the case record.

When a social services district approves an application for community coverage, the applicant must be given the appropriate notice of decision (Attachment II or III), depending on whether the applicant is eligible subject to a spenddown. When a social services district denies an application for community coverage, the applicant must be given notice of the denial using existing Department form DSS-3622 (Attachment IV).

When a social services district makes a decision on an application for full MA coverage, the district must follow current procedures with respect to providing appropriate notices to the applicant. An applicant determined eligible for institutional care must be given the existing form DSS 4022, Notice of Intent to Establish a Liability Toward Chronic Care (Attachment V). An applicant who is currently eligible for community coverage, applies for institutional care, but is denied eligibility for institutional care must be given the revised DSS 4146 Notice of Decision on Your Medical Assistance Application (Full Coverage) (Attachment VI) which has been revised by the addition of a section to indicate a denial of coverage for nursing home services for any reason. In addition, this form (DSS 4146) will continue to be used for its current purposes as explained in 89 ADM-45, "Transfer of Resource Provisions Under the Medical Assistance Program".

These notices are mandated, and must be reproduced locally until such time as they become available from the Department. These notices must not be modified, except for being produced on local letterhead, unless the Department has granted approval for a local equivalent in accordance with the procedures specified in the Local District Manager's Guide.

VI. SYSTEMS IMPLICATIONS

Upstate: Currently, coverage code 10 (All Services Except Long-Term Care) is used in conjunction with an Anticipated Future Action (AFA) code of 505 (End of Property Transfer Prohibition) with a specific end date to indicate an individual for whom a penalty period has been established. Until a separate coverage code is established for persons electing community coverage, for all cases determined eligible for the community benefit package, enter coverage code 10 , and do not make a corresponding entry into the AFA field. For those recipients who are currently in a penalty period, or receive one in the future, continue to use an AFA code 505. The presence of coverage code 10 in combination with the AFA code 505 will allow social services districts to track those recipients who are in a penalty period.

New York City: Currently, coverage code 10 (All Services Except Long-Term Care) is used to indicate an individual for whom a penalty period has been established. Until a separate coverage code is established for persons electing community coverage, for all cases determined eligible for the community benefit package, enter coverage code 10 for these persons, as well.

VII. EFFECTIVE DATE

The provisions of this ADM shall be effective with all applications received on or after July 1, 1995.

Richard T. Cody
Acting Deputy Commissioner
Division of Health & Long Term Care

Community Coverage Notices

(Used in districts that elect to give MA applicants the choice between full or community coverage)

Description

Attachment

I. Request for Simplified Asset Review for Medicaid Eligibility (DSS-4481, New)

Must be signed by all MA applicants to indicate whether they want full or limited asset review.

II. Notice of Decision On Your Medical Assistance Application (Community Coverage) (DSS-4489, Revised)

Acceptance notice for community coverage in a non-spenddown case.

III. Notice of Decision On Your Medical Assistance Application (Community Coverage - Excess Income) (DSS-4489, Revised)

Acceptance notice for community coverage in a spenddown case.

IV. Notice of Decision On Your Medical Assistance Application (DSS-3622)

Acceptance/denial notice of full coverage when the individual is not in need of institutional care.

V. Notice of Intent to Establish a Liability Toward Chronic Care (DSS-4022)

Notification of acceptance for full coverage when the individual is in need of institutional care.

VI. Notice of Decision On Your Medical Assistance Application (Full Coverage) (DSS-4146, Revised)

Denial notice of nursing home services for a recipient already in receipt of community coverage who applies for nursing home services but who is ineligible for those services due to a prohibited transfer.

NOTE: When a social services district makes a decision on an application for full Medicaid coverage, the district must follow current procedures with respect to providing appropriate notices to the applicant.