RESOURCES

RESOURCE DOCUMENTATION REQUIREMENTS

Description: Resource documentation requirements vary depending on the Medicaid coverage option selected by the A/R. In some instances, the A/R is allowed to attest to the value of their resources.

Policy: Coverage options must be offered to all Medicaid A/Rs who have a resource test.

References:

SSL Sect. 366
366-a(2)
366-ee

Dept. Reg. 360-2.3(c)(3)
360-2.3
360-4.4
360-4.6(b)

ADMs 10 OHIP/ADM-01
04 OMM/ADM-6

INF 05 ADM/INF-2

GISs 09 MA/027
05 MA/012
05 MA/004

Interpretation: When SSI-related individuals, who have a resource test apply for Medicaid, they are asked to choose one of the following coverage options:

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 (this option is available only to individuals in Nursing Home Level of Care).

NOTE: Effective for eligibility periods beginning on or after January 1, 2010 FHPlus and non-SSI-related Medicaid A/Rs will not have resources considered in determining eligibility. This change includes the following Medicaid categories: Single/Childless Couples (SCC), Low Income Families (LIF), ADC-related (including adults who spend down excess income to the Medicaid income level), children under 21 years of age when comparing income to the Medicaid income level (Under age 21), and parents living with their dependent child(ren) under age 21 with income at or below the Medicaid income level (FNP Parents).

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In determining eligibility, resources are never considered for pregnant women and infants under one year of age. Resources are also not considered for children over age one but under age 19.

In addition, there is no resource test for applicants for the Family Planning Benefit Program, Medicaid Cancer Treatment Program, the Medicare Savings Program including the Qualified Individual Program (QI-1), Qualified Medicare Beneficiaries (QMB) and Specified Low Income Medicare Beneficiaries (SLIMB), AIDS Health Insurance Program (AHIP) and policy holders who have utilized the minimum required benefits under a total asset Partnership for Long-Term Care insurance policy. (See **RESOURCES** NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE)

1. Community Coverage without Long-Term Care services include all Medicaid covered care and services except nursing facility services and community-based long-term care services. If a Medicaid SSI-related A/R elects this coverage, the A/R may attest to the amount of his/her resources. The SSI-related A/R is not required to itemize their resources on the application but is required to do so at renewal.

NOTE: A/Rs of all categories continue to be required to provide documentation of any trust agreement in which the A/R is named the creator or beneficiary. This enables the district to determine the availability of any trust income and/or principal. If an SSI-related A/R has an irrevocable pre-need funeral agreement, a copy of the agreement must be provided to the district in order for the district to verify the type of agreement.

Short-term Rehabilitation Services – SSI-related individuals who attest to their resources can receive Medicaid coverage for short-term rehabilitation services (one commencement/admission in a 12-month period, of up to a maximum of 29 consecutive days of each of the following (for a total of 58 days before being required to provide applicable resource documentation): Certified Home Health Agency (CHHA) services; and nursing home care.) Short-term rehabilitation begins on the first day the A/R receives CHHA services or is admitted to a nursing home on other than a permanent basis, regardless of the payer of care and services. If an SSI-related individual does not apply for Medicaid coverage for a commencement of CHHA services or nursing home admission, that commencement/admission is not

counted toward the one commencement/admission limit per the 12-month period.

NOTE: If an SSI-related Medicaid A/R states a transfer was made but does not provide documentation of the transfer, the SSI-related A/R is not eligible for short-term rehabilitative nursing home care admission and that commencement/admission is not counted toward the one commencement/admission limit per the 12-month period.

In the event that that short-term rehabilitation exceeds 29 days, the SSI-related individual must provide proof of his/her resources in order for Medicaid coverage to be established for the rehabilitation services beyond the 29th day. Proof of resources includes resource documentation for prior periods in accordance with transfer of resource policies for nursing facility services (See **RESOURCES** TRANSFER OF ASSETS) and current resource documentation for CHHA services.

If an SSI-related recipient who attested to his/her resources subsequently requests coverage for long-term care services, the date of the request shall be treated as the date of a new application for purposes of establishing the effective date and the three-month retroactive period for increased coverage. The SSI-related recipient must complete the "ACCESS NY Supplement A" and send in the requested resource documentation in order for eligibility to be determined for the requested coverage.

SSI-related Medicaid A/Rs who attest to the amount of their resources may enroll in a managed care plan, provided the SSI-related individual is not enrolling in a managed long-term care plan. Participation in a managed long-term care plan requires resource documentation of current resources for care in the community and resource documentation for prior periods in accordance with transfer of resource policies for care in a nursing home. (See **RESOURCES** TRANSFER OF ASSETS) Once enrolled, the SSI-related recipient will be eligible for all care and services covered by the plan as well as any wraparound services that are covered under Medicaid fee-for-service.

Attesters who are eligible for Medicaid subject to a spenddown requirement may participate in the Excess Income/Optional Pay-In Program. (See **INCOME** EXCESS and PAY-IN) Local social services districts may continue to verify the accuracy of the resource

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information provided by the A/R through collateral investigations. If there is an inconsistency between the information reported by the A/R, and the information obtained by the district is current, the district shall redetermine the recipient's eligibility based on the new information. If the district requires further information about a particular resource in order to make an eligibility decision, the recipient must be notified to provide the necessary information.

2. Community Coverage with Community-Based Long-Term Care includes all Medicaid covered care and services including HCBS waiver services but not nursing facility services. The coverage does, however, include short-term rehabilitative nursing home care. If an SSI-related Medicaid A/R elects this coverage, the A/R must provide documentation of his/her current resources.

NOTE: If an SSI-related Medicaid A/R states a transfer was made but does not provide documentation of the transfer, the A/R is not eligible for short-term rehabilitative nursing home care.

An otherwise eligible SSI-related individual who fails or refuses to provide adequate resource documentation shall be denied Community Coverage with Community-Based Long-Term Care and shall be authorized for Community Coverage without Long-Term Care if adequate information (not documentation) regarding the individual's resources is provided.

SSI-related recipients with Community Coverage with Community-Based Long-Term Care may be enrolled in managed care and managed long-term care.

3. Medicaid coverage for all covered care and services includes nursing facility services. If an SSI-related Medicaid A/R elects this coverage, the A/R must be in receipt of nursing home care and provide documentation of his/her resources for the prior periods in accordance with transfer of resource policies . (See **RESOURCES** TRANSFER OF ASSETS)

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If an SSI-related Medicaid A/R does not provide documentation of his/her resources for prior periods in accordance with transfer of resource policies, but does provide current resource documentation, the local district determines eligibility for Community Coverage with Community-Based Long-Term Care. If the SSI-related A/R provides information on the amount of his/her current resources but does not provide supporting documentation, the district determines eligibility for Community Coverage without Long-Term Care.

Temporary Assistance and Supplemental Security Income (SSI) recipients are authorized for Medicaid coverage for all covered care and services. Individuals who lose SSI eligibility continue to be eligible for Medicaid coverage of all covered care and services until a separate determination is made. (See **CATEGORICAL FACTORS** SEPARATE HEALTH CARE COVERAGE DETERMINATION) Unless the individual's SSI was discontinued due to a prohibited transfer, the individual is not required to provide documentation of his or her resources for the purpose of the ex-parte eligibility determination.

Individuals who are ineligible or lose Temporary Assistance for failure to document resources are referred to Medicaid for a separate determination.

Disposition: Although SSI-related Medicaid applicants choose a coverage option at application, such recipients have the right to supply proof of their resources at any time for a change in coverage. If an individual becomes in need of a service for which he/she does not have coverage, the individual must contact his/her local district immediately for assistance in obtaining the Medicaid coverage required.