RESOURCES

RESOURCE DOCUMENTATION REQUIREMENTS

Description: **Resource documentation requirements vary depending on the Medicaid coverage option selected by the A/R.**

Policy: **Coverage options must be offered to all Medicaid A/Rs who have a resource test, including Single Individuals and Childless Couples (S/CCs).**

References:

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

Dept. Reg. **360-2.3(c)(3)**

ADM **04 OMM/ADM-6**

GISs **05 MA/012**
05 MA/004

Interpretation: **When 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.**

NOTE: There is no resource test for pregnant women and children under one year of age. There is also no resource test for children between the ages of one and 19 who have income below the applicable federal poverty level; for the Family Planning Benefit Program, Breast and Cervical Cancer Treatment Program, or the Qualified Individual Program; or for policy holders who have utilized the minimum required benefits under a Partnership for Long-Term Care insurance policy.

1. **<u>Community Coverage without Long-Term Care</u> services includes all Medicaid covered care and services except nursing facility services and community-based long-term care services (see page 303.9). If a Medicaid A/R elects this coverage, the A/R may attest to the amount of his/her resources.**

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NOTE: A/Rs 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 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.

In order to determine eligibility for Community Coverage without Long-Term Care for S/CC applicants, the local district must ask if a prohibited transfer has been made in the past 12 months. S/CCs are subject to a 12-month look-back period. If the S/CC applicant states no transfer has been made and there is no indication of a transfer, eligibility may be determined. If the S/CC individual or couple states that a transfer has been made in the past 12 months, Medicaid coverage shall be denied. (See page 361 for transfer of assets rules for S/CC A/Rs.)

Short-term Rehabilitation Services - 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: 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 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 a 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.

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In the event that that short-term rehabilitation exceeds 29 days, the 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 the past 36 months (60 months for trusts) for nursing facility services (see page 353) and current resource documentation for CHHA services.

If a 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 recipient must complete the "Long-Term Care Change in Need Resource Checklist" and send in the requested resource documentation in order for eligibility to be determined for the requested coverage.

Medicaid A/Rs who attest to the amount of their resources may enroll in a managed care plan, provided the 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 the 36 months (60 months for trusts) for care in a nursing home. Once enrolled, the 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 pages 239 and 248).

Local social services districts may continue to verify the accuracy of the resource 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.

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2. **Community Coverage with Community-Based Long-Term Care includes all Medicaid covered care and services except nursing facility services (see page 303.9). The coverage does, however, include short-term rehabilitative nursing home care. If a Medicaid A/R elects this coverage, the A/R must provide documentation of his/her current resources.**

   NOTE: If a 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.

   If an otherwise eligible S/CC applicant states that no transfer has been made in the past 12 months and there is no indication a transfer was made, Community Coverage with Community-Based Long-Term Care may be authorized. If an S/CC individual or couple states a transfer has been made within the past 12 months, Medicaid coverage will be denied. (See page 361 for transfer of assets rules for S/CC A/Rs.)

   An otherwise eligible 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.

   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 (see page 303.9). If a Medicaid A/R elects this coverage, the A/R must provide documentation of his/her resources for the past 36 months (60 months for trusts) (see page 353). S/CCs must provide resource documentation for the past 12 months (see page 361).**

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If a Medicaid A/R does not provide documentation of his/her resources for the past 36 months (60 months for trusts) or 12 months for an S/CC, but does provide current resource documentation, the local district determines eligibility for Community Coverage with Community-Based Long-Term Care. If the 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 page 47). 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 for Community Coverage without Long-Term Care or Family Health Plus.

Disposition:

Although Medicaid applicants choose a coverage option at application, 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. Medicaid A/Rs who can reasonably expect to need long-term care services are encouraged to provide proof of their resources in advance of the need for such services. This will help prevent any unnecessary delay in service delivery that may result from absence of resource documentation.

Resource Verification Indicator (RVI) values are used by local districts to identify if a Medicaid recipient:

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attested to his/her resources; verified current resources; verified resources for 36 months (60 months for trusts); transferred resources; or is exempt from resource verification.

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 ▪ Residential treatment facility ▪ Managed long-term care in the community ▪ Personal care services ▪ Non-waiver services 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 ▪ 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 ▪ Home and community-based waiver services provided through 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	Once commencement/admission in a 12-month period of up to 29 consecutive days of: ▪ Nursing home care ▪ Certified home health care