

# **Attachment H**

# **Excess Income**

**2018**

# Excess Income - Training Agenda 2018

9:00AM –4:30PM

- Introduction and Overview of Agenda
- Excess Income to include:
  - Definition of Excess Income
  - Who may participate with the program
  - Types of coverage an individual may receive
  - Meeting an excess utilizing bill or cash
  - Principal Provider Subsystem
  - Pay In Subsystem
- Evaluations, Certificates, and Closing

## **Excess Income - Learning Objectives**

By the end of this training, participants will be able to:

1. Understand how an excess is calculated
2. Differentiate who can and cannot participate with the Excess Income program
3. Determine the type of coverage individuals can received
4. Meeting an excess using bills and/or cash
5. Subsystems associated with the Excess Income program



# Excess Income

## 1. Excess Income/Spenddown

- Definition: Available net income in excess of the Medically Needy Level

## 2. Who May Participate?

- Individuals who are FP categorically
  - SSI-R individuals who have a resource test must also be resource eligible under the MA resource standard; SSI-R individuals who have excess resources may also be eligible for the Excess Resource Program.
  - Pregnant women and children who are not eligible under the appropriate multiples of the Federal Poverty Level must spenddown to the Medically Needy Level.

## 3. Medicaid Coverage Available Under Excess Income Program

- **Provisional Coverage** – “06” Coverage – Provided to an A/R who has met the eligibility requirements for the excess income program but has not yet met their monthly spenddown requirement.
- **Outpatient Care** – Provided to a A/R who meets spenddown on monthly basis.
- **Inpatient and Outpatient Coverage** – Provided to a A/R who meets a six-month excess.

It is necessary for any A/R who wishes Medicaid payment for inpatient hospital charges to meet a consecutive six-month excess.

A six-month excess may include inpatient bills, outpatient bills, or a combination of both inpatient and outpatient bills.

- There are limited coverage packages for SSI-R individuals who attest to the value of their resources, only provide documentation of the current value of their resources, or are in a prohibited transfer period.



## Excess Income, cont'd.

### 4. Meeting a Monthly Excess or Spenddown

- When a A/R shows that he or she has either paid or obligated the excess income toward a medical need (met their excess income), the appropriate type of coverage is granted.
- An A/R shows that he or she has met the excess income by submitting a paid or incurred medical bill to the agency.
- The amount and nature of the medical bill submitted by the A/R determines the length of time for which a particular type of coverage is granted.

### 5. Factors Affecting Applicability of Bills

- Timeframes
- Paid vs. Incurred (viability)
- Type of Bill
- Prioritization of Bills
- Accounting Period

### 6. Timeframes

- **Pre-Retroactive Period** - the period prior to the first day of the third month prior to the month of application
- **Retroactive Period** - any portion of the three month period immediately prior to the month of application
- **Application Month/Current Period** - the month in which an individual applied for assistance or, after the month of application, the month in which the individual is currently seeking coverage
- **Prospective Period** - any period of eligibility which continues into the future



## Excess Income, cont'd.

### 7. Paid Bills

- Bills paid in the pre-retroactive period cannot be used to grant eligibility.
- *Anchored* in the accounting period paid.

An exception is made for expenses incurred and paid in the three-month retroactive period. When no part of the retroactive period is included in the first prospective accounting period, expenses incurred and paid during the retroactive period, which have not been used previously to establish eligibility can be deducted from income in the first prospective accounting period. (96 ADM-15)

- Credit may be carried forward for no more than six months, or until there is a break in coverage.

### 8. Unpaid (incurred) bills

- Must be viable.
- Unpaid bills from the retro and pre-retro period can be used to grant eligibility.
- *Credit* generally not carried to subsequent months if bill payable by Medicaid.
- Unpaid bills not paid by Medicaid may be carried forward until there is a break in coverage.
- After third party payments.

### 9. Types of Bills

- Medical Expenses
- Transportation
- Prescription Drugs
- Surgical supplies/Medical Equipment/Prosthetic Devices
- Non-Covered Services
- Medical expenses for an individual for whom the A/R is legally responsible.



## Excess Income, cont'd.

- Medical expenses from a legally responsible relative whose income is available to the A/R.
- Non-Participating Provider Services\*  
\*Once Medicaid coverage is given, the recipient must receive services from MA providers in order for the MA payment to be made. Credit or refunds will not be provided for covered services rendered to the recipient by non-participating providers.
- Over-the-Counter Drugs
- Medicaid Co-pays
- Medical expenses paid/incurred by a public program.

### 10. Prioritization of Bills

- a. Bills not payable by the Medicaid Program such as:
  - Paid bills
  - Non-Covered Services
  - Non-Participating Providers
  - Medical expenses from a legally responsible relative whose income is available to the A/R.
  - Medicaid Co-pays.
- b. Unpaid medical bills (viable, oldest first).
- c. Medical bills payable by Medicaid.

### 11. Accounting Period

- **Accounting Period** – a period of time, extending from one to six months, over which medical bills are applied to excess income
- **First Prospective Period** – the first accounting period that includes the month of application
- **Current Period** – an accounting period that occurs after the first prospective period



## Explanation of the Excess Income Program

If your monthly income is over the Medicaid level, you may still get help with your medical bills. This letter explains how to do that. The amount your income is over the Medicaid level is called excess income. The Notice of Decision letter you received tells you the amount of your excess income. Once you have medical bills at least equal to your excess income (spenddown or surplus) which is like a deductible, Medicaid will pay your medical bills for the rest of the month.

### How to get Medicaid through the Excess Income Program

First, you must be under age 21, age 65 or older, certified blind or certified disabled, pregnant or a parent of a child under age 21. This allows you to become eligible for Medicaid even though your monthly income is too high. You can spenddown to the Medicaid level in one of two ways:

#### 1. *Outpatient Care and Services (One Month Eligibility)*

If you need outpatient care, in a hospital, clinic or doctor's office, prescription drugs or medical supplies, you may be able to get help with these bills. If you have medical bills that are equal to or more than your monthly excess income, you can get Medicaid outpatient services for one month. The Excess Income Program can provide outpatient coverage for one month at a time.

First, you need to tell your local Department of Social Services that you want to be in the Excess Income Program. You must then bring in or send your medical bills to your local Department of Social Services when they at least equal your excess income amount. These bills can be paid or unpaid. You will need to do this each month you need outpatient care.

You may be able to get long-term care services like adult day health care, personal care services and the Assisted Living Program. Your social services worker will be able to tell you if you are eligible for these services.

Or

#### 2. *Inpatient/Hospital Care and Services (Six Months Eligibility)*

If you need hospital care or need help paying your hospital bills, you may be able to get Medicaid inpatient services, in addition to the outpatient care described above. You must have medical bills that are at least equal to your monthly excess income amount for six months. These bills can be paid or unpaid. They can also be for medical services other than hospital care.

Once your medical bills at least equal your excess income amount for six months, you must bring or send these bills to your local Department of Social Services. You will then receive Medicaid for six months.

**Pay-In Option** If you do not have medical bills but you need medical care, there is another option called the Pay-In Program. You can pay your monthly excess income amount for any month to your local Department of Social Services. You should only do this if you need services in that month. Ask your social services worker about this option.

### Once You Enroll in the Excess Income Program

- Each month you need Medicaid services, bring in, send, or fax (if available in your county) your medical bills to your local Department of Social Services. Only send these bills when they are equal to or more than the amount of your excess income.
- You should make doctors' appointments or fill prescriptions early in the month. This will help you meet your excess income amount faster. Once you reach your excess income amount, Medicaid will pay for covered services for the rest of the month.

## **Bills You Can Use Toward Your Excess Income**

- You may use bills from a doctor or other medical provider who does not take Medicaid.

***Important Note:*** *Once you have enough bills to meet your excess income for any month, Medicaid will only pay medical bills in that month from a doctor, pharmacist, or other provider who is in the New York State Medicaid program. You need to see if your doctor or other medical provider is enrolled in Medicaid so your bills can be paid. You cannot use bills from a non-Medicaid provider until the next month when you need to meet your excess income again.*

- You can use any part of a bill that Medicare or private insurance does not pay. You cannot use a bill that Medicare or private insurance will pay in full.
- Bills may be for medical care given to you, your spouse, or your children who are under 21 years old. If you provide medical support for a child not living with you, you may be able to use the child's bills. Medical bills for your parent(s) may also be used toward meeting your monthly excess if you are under 21 and live with your parent(s).
- You can use unpaid medical bills from prior months to meet your current monthly excess income. Once you use a bill to meet your excess income, you cannot use it again.

### **You can also use the following bills to meet your excess income amount:**

- The cost of transportation to get to and from medical appointments (in most cases);
- Medical bills or payments made to therapists, nurses, personal care attendants and home health aides (as ordered by a doctor);
- Prescription drug bills;
- Payments made for surgical supplies, medical equipment, prosthetic devices, hearing aids and eyeglasses (as ordered by a doctor); and
- Any bills paid by public programs of the State or county like the Elderly Pharmaceutical Insurance Program (EPIC) or the AIDS Drug Assistance Program (ADAP), and your copayments.

### **In addition, you can use medical bills that the Medicaid program does not cover like:**

- Chiropractor services and other non-covered medical services;
- Co-payments you are charged when you receive certain Medicaid services;
- Some over-the-counter drugs and medical supplies such as bandages. You can use these to meet your spenddown if your doctor has ordered them. Bills for cosmetics and other non-medical items are not allowed; and
- Any out-of-pocket costs associated with the Medicare Prescription Drug Program such as premiums, co-payments and deductibles.

**If you have questions, please contact your county's Department of Social Services.  
For more information go to [http://nyhealth.gov/health\\_care/medicaid/](http://nyhealth.gov/health_care/medicaid/)**

*Regulations require that you immediately notify your county's Department of Social Services of any changes in need, income, resources (if you are age 65 or older, certified blind or certified disabled), living arrangements and address.*

## OPTIONAL PAY-IN PROGRAM FOR INDIVIDUALS WITH EXCESS INCOME

Individuals whose income exceeds the Medical Assistance income limit may still receive help with medical bills. The form DSS-4038, "EXPLANATION OF THE EXCESS INCOME PROGRAM" explains that if you bring in or send us your medical bills each month which are equal to or more than the amount of your excess income, you may receive coverage for any other outpatient medical expenses you incur from a Medical Assistance provider in that month. Explained below is another way you can get Medical Assistance coverage.

Instead of bringing or mailing in your medical bills each month, you can pay to this agency the amount of your income that is over the limit. If you decide to pay this money to us, you will be given outpatient coverage for the month you are paying for, and will not have to wait until you incur a medical bill. If you pay a total of six months of excess income, you will be given outpatient and inpatient coverage for that six month period. Once you are given coverage, you can use your Medical Assistance card to obtain services from your doctor or other medical provider. You must be sure the provider accepts payments from the Medical Assistance program before you receive the service.

If you pay your excess income to this agency, and then get or pay a bill for medical services that Medical Assistance does not cover (for example, chiropractor's service), we will give you a refund or we will give you a credit toward the next available uncovered month. You must bring in or send to us the paid or unpaid bill in order to get a credit or refund.

\*Remember, we will not pay for or give credit for any bill or portion of a bill that is covered by **Medicare** or other health insurance that you have.

If you decide to pay your excess income to the agency, from time to time we will review the amount of all the claims we have paid for you, and compare this amount to the amount you have paid. If you have paid more than you should have, we will decide to give you a refund or give you credit for coverage in another month. We will make this decision based on your circumstances.

You should consider the following before deciding to take part in the PAY-IN PROGRAM:

1. Unless you know that you will need medical services during a month, it is **NOT** to your benefit to pay us your excess income that month.
2. If you pay your excess income for a period and then do not use your Medical Assistance card, it may take at least a year for us to give you a refund or credit. This is because we must wait to see if any claims have been paid for you for that period.
3. If you decide you want to pay your excess income to this agency, you may do so every month, or only in those months that you know you will need medical services. If you want, you may pay us for more than one month at a time, up to six consecutive months. However, if you decide to pay your excess income and then do not make a payment to us for three consecutive months, you **MAY** receive a notice of our intent to close your case. You may reapply for Medical Assistance if you incur or expect to incur medical expenses at least equal to your excess income and wish to make a payment or submit bills to receive coverage.

If you did not provide proof of your resources when we determined your eligibility for Medical Assistance, you will not be eligible for coverage of long-term care services. Please read the enclosed "Explanation of the Excess Income Program" for information about coverage of long-term care services. The information will also tell you what you need to do in order to have coverage of inpatient hospital care, home care or nursing home care.

**YOUR MEDICAL ASSISTANCE EXAMINER CAN ANSWER ANY QUESTIONS YOU HAVE  
AND HELP YOU DECIDE IF PAY-IN IS RIGHT FOR YOU.**

## Spendedown Sheet for Applicants

Excess Amount: \_\_\_\_\_ Eff: \_\_\_\_\_

Case Name: \_\_\_\_\_

CIN: \_\_\_\_\_ Assoc. CIN: \_\_\_\_\_

Case Number: \_\_\_\_\_

RVI: \_\_\_\_\_ OTPT Cov. Code: \_\_\_\_\_ INPT Cov. Code: \_\_\_\_\_

Date	Credit Forward	Cash	Bills/Receipts	Paid/Unpaid	Date of Service	Vendor	Viable Y/N	Month(s) Covered	Credit

6 months full coverage entered:

Comments: \_\_\_\_\_

From \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

From \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

From \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PROVIDER or MANAGED LONG TERM CARE PLAN/RECIPIENT LETTER**  
(Financial Obligation of Recipient Toward Medical Expenses)

<b>To: (Name/Address of Provider or Managed Long Term Care Plan)</b>	<b>Concerning: (Name/Address of Recipient)</b>	<b>CIN #</b>
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This report is to advise the Medicaid provider or Managed Long Term Care plan and the Medicaid recipient of the sharing of certain costs between the recipient and the Medicaid program.

The Medicaid provider named on this form must take note of all payment exclusions/limitations as noted on this form before billing the Medicaid program for this recipient.

Medicaid has been authorized for the above recipient for the period 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/resources 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 Medicaid. 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 Medicaid program.

Bill Date	Date of Service	Patient's Name/Account Number	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 Medicaid rate or fee, the balance, if any, may be billed by your medical provider to the Medicaid program.

Bill Date	Date of Service	Patient's Name/Account Number	Amount

The Managed Long Term Care plan must reduce the excess income amount collected from the Medicaid recipient by the amount shown below.

If you owe your excess income to a Managed Long Term Care plan and have provided proof of medical expenses that you have paid, the amount of the medical expenses is applied toward the amount you owe. You have provided proof of paid medical expenses of \$\_\_\_\_\_ for the month of \_\_\_\_\_. After deducting these medical expenses from your excess income of \$\_\_\_\_\_, the amount you owe the Managed Long Term Care plan is \$\_\_\_\_\_.

<b>ELIGIBILITY WORKER'S SIGNATURE</b> X	<b>TELEPHONE NO.</b>	<b>DATE</b>
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**NOTE TO AGENCY RECIPIENT AND PROVIDER:  
SEE REVERSE FOR IMPORTANT INFORMATION/INSTRUCTIONS.**

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

**MANAGED LONG TERM CARE PLAN, PLEASE NOTE:** Since the plan is responsible for collecting the spenddown amount from the recipient, this form is sent to advise you that the recipient submitted receipts for paid medical expenses, and the amount indicated in this letter has been applied toward their monthly spenddown amount.

**RECIPIENT, PLEASE NOTE:** You may receive a separate form for each medical provider that you used to become eligible for Medicaid. 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 to be used to help you become eligible for the Medicaid 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 are enrolled in a Managed Long Term Care plan, pay your excess income to the plan, and you have submitted paid medical bills; this form is being sent to you to show you the amount of your excess income after deducting your paid medical bills from your excess income. Your reduced excess income amount will be collected by the Managed Long Term Care plan.

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 their bill(s); where bills from more than one provider are being used to establish eligibility.

# **Bills that Cannot be Utilized to Meet a Spenddown**

- Filters for any equipment such as air conditioners or humidifiers
- Air Conditioners
- Exercise equipment
- Special clothing used for weight loss program, such as a swimming suit or jogging outfit
- Batteries\*, generators or service contracts for medical equipment
- Cell phones, Lifeline (telephone discount)
- Toothpaste
- Weight loss or fitness programs
- Feminine hygiene products
- Herbal remedies
- Expenses related to guide dogs

\*Hearing aid batteries are an allowable expense



## Medicaid Covered Services

### **Federally Mandated Services:**

- Inpatient hospital services
- Outpatient hospital service
- Physician services
- Medical and surgical dental services
- Nursing facility services for individuals aged 21 or older
- Home health care (nursing, home health aide, medical supplies & equipment)
- Family planning services & supplies
- Rural health clinic services
- Laboratory & x-ray services
- Nurse practitioner services
- Federally-qualified health center services
- Midwife services
- Early & periodic screening, diagnosis & treatment (EPSDT) services for individuals under 21 (Child/Teen Health Plan in NYS)
- Medicare coinsurance & deductibles for qualified Medicare beneficiaries for: chiropractors, podiatrists, portable x-ray & clinical social work services

### **Non-Mandated Services (Covered by New York State Medicaid):**

- Free-standing clinic services
- Nursing facility services for under 21
- Intermediate care facility services for the developmentally disabled
- Optometrist services & eyeglasses
- Drugs – prescription and non-prescription
- Physical, speech & occupational therapy
- Prosthetic devices & orthotic appliances
- Dental services
- Audiology & hearing aids
- Clinical psychologist services
- Private duty nursing
- Diagnosis, screening, preventive & rehabilitative services
- Personal care services
- Transportation to covered services
- Hospice
- Case management
- Inpatient psychiatric services for individuals under 21 & over 65





## Excess Income Case – Example One

In June, Charlie White, SSI-related, has applied for MA for himself and his wife, Nancy, and child, Junior. Charlie has attested to the total value of their resources of \$3500. The local agency has determined that Charlie has a spenddown of \$55 monthly and Nancy and Junior have a spenddown of \$160 monthly. The White's have paid and unpaid bills for June and each have scheduled doctor appointments for July. Charlie presents the following medical bills:

- Nancy's unpaid, viable, January bill of \$210;
- Junior's paid dentist bill of \$165 for June (non MA provider);
- Charlie's unpaid doctor bill of \$850 for June (doctor accepts MA );
- Junior's unpaid doctor bill of \$125 for June (doctor accepts MA).

Questions:

Is the family eligible?

If so, for how long?



## Excess Income Case – Example Two

Homer Simmons, aged 58 and certified disabled through Local District Social Services, applies for Medicaid in September. Homer has provided proof of his current resources and is determined eligible as follows:

June spenddown of	\$74.26
July spenddown of	83.91
August spenddown of	87.83
September and on going spenddown of	91.26

Homer does not contact the agency again until November 15<sup>th</sup> when he comes in with a bag full of bills.

Going through his bills, determine how each bill can be used to grant coverage for Homer.





## Excess Income Case – Example Three

Shannon Haxton, aged 19, applies for Medicaid in May. Shannon is eligible for Medicaid as follows:

February spenddown of	\$65.50
March spenddown of	120.00
April spenddown of	83.21
May and ongoing spenddown of	31.55

With her application, Shannon submits her medical bills. Shannon also informs you that she was in Albany Medical Hospital for three (3) days during April, but does not yet have a bill for that.

Using the bills Shannon submitted, determine how each bill can be used toward Shannon's spenddown.



+-----+  
| LOCAL COMMISSIONERS MEMORANDUM |  
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Transmittal No: 91 LCM-207

Date: November 18, 1991

Division: Medical Assistance

TO: Local District Commissioners

SUBJECT: Use of Medical Expenses Paid/Incurred by ADAP to Meet Medical Assistance Spenddown Amounts

ATTACHMENTS: None

This Local Commissioners Memorandum (LCM) is to clarify procedures for establishing the amount of medical expenses paid for participants in the AIDS Drug Assistance Program (ADAP) for the purposes of meeting the Medical Assistance (MA) spenddown amount of an applicant/recipient.

Administrative Directive 91 ADM-11 informed social services districts of a change in the Social Security Act which allows the use of medical and remedial care expenses paid by a public program of the State, or a political subdivision of the State, as incurred medical expenses under the spenddown provisions of the MA program. ADAP, which is administered by the New York State Department of Health, qualifies as a public program for purposes of this requirement.

The following procedures have been established for ADAP participants who are MA eligible with an income spenddown:

- 
- o Each ADAP participant who is MA eligible with an income spenddown will receive a special ADAP identification card which will identify the individual as an ADAP participant who has an MA spenddown.
  - o When the individual requires medication and presents this card to the pharmacy, the pharmacy must first use the Common Benefit Identification Card (CBIC) to determine that the individual is in fact not eligible under MA.
  - o If the individual is not MA eligible, the medication will be provided and reimbursement sought from ADAP. The pharmacy will then issue a receipt to the individual in the amount that is billed to ADAP.
  - o The individual is responsible for submitting the receipt to the social services district to be applied as an incurred medical expense to meet any spenddown.

This procedure will be used only for ADAP participants who do not have any third party health insurance available for prescription drug coverage.

Questions may be directed to your MA Eligibility County Representative at 1-800-342-3715, extension 3-7581, or 212-417-4853 in New York City.

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Jo-Ann A. Costantino  
Deputy Commissioner  
Division of Medical Assistance

# Medicaid Expenses Paid/Incurred by a Public Program

**To: DSS** \_\_\_\_\_ **RE: Name** \_\_\_\_\_

**Address** \_\_\_\_\_ **Address** \_\_\_\_\_

\_\_\_\_\_

**SS# or CIN** \_\_\_\_\_

Section 1902(a)(17) of the Social Security Act permits incurred medical or remedial care expenses paid by certain public programs to be applied toward the spenddown amount of a medical Assistance applicant/recipient. The following is a description of the medical services provided to the above named individual during the period \_\_\_\_\_.

Description of Medical Service	Provider Name	Date of Service	Original Bill Amt.	Health Insurance Payment	Client Payment	Actual Amt* Incurred by Public Program
* This amount is to be applied to the spenddown of the above named recipient.						

Comments:

\_\_\_\_\_

I hereby certify that the care, services, and supplies itemized have in fact been furnished; that such records as are necessary to disclose fully the extent of care, services and supplies provided to the above-named individual will be kept, and information will be furnished regarding the care, services and supplies itemized as the local social services agency or the State Department of Social Services may request; and that the undersigned understands that any false claims, statement, or documents, or concealment of a material fact may be prosecuted under applicable Federal and State laws.

Public Program: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Representatives Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **WMS Medical Assistance Subsystems**

- **Principal Provider**
- **Pay-In/Excess Income**



**WMS  
Principal Provider  
Subsystem**

SANBEE







# WMS Principal Provider Subsystem

## Principal Provider

Provides payment controls for individuals who have some liability towards the cost of care to medical facilities.

Accessed off the main menu of WMS through screen 25, the following functions are allowable entries for the Principal Provider Subsystem, Input, Inquiry, and Audit:

- |                       |     |  |
|-----------------------|-----|--|
| <b>Input Screen</b>   | (I) | Accessed to enter and store an initial Transaction, update or delete records already stored.       |
| <b>Inquiry Screen</b> | (Q) | Displays entries that have been accepted by WMS  |
| <b>Audit Screen</b>   | (A) | Displays all stored transactions on the WMS subsystem including changes, (CL), and deletions, (DL) |



## WMS Principal Provider Subsystem, cont'd.

Principal Provider data is initially entered and/or modified on the input screen, WMPPIN – Principal Provider Input Screen. Access to WMPPIN is obtained by entering:

P- Principal Provider for SUBSYSTEM, I for FUNCTION, CIN, CASE NUMBER, WORKER ID ON WMAMNU – Medical Assistance Subsystem Menu and transmitting. The individual must currently have or have had MA coverage in the transaction district.

If there is no prior stored Principal Provider data, the WMPPIN screen is returned with system generated data (listed below) but no historical data. If prior data was stored, the WMPPIN screen displays the historical data as well as the following system generated data:

1. CLIENT ID
2. NAME
3. CASE NUMBER
4. TRANSACTION INPUT DATE
5. TRANSACTION DISTRICT
6. WORKER ID

The appropriate data from the Principal Provider Data Input Form (DSS-3477) is entered on the input line and transmitted. A successful input transaction is acknowledged by the message INPUT ACCEPTED and the accepted data is moved below the input line. If there are system-detected errors, the fields in error are returned blinking and either an error message or the message EXAMINE BLINKING FIELDS and the error number(s) corresponding to the error(s) will be displayed at the bottom of the screen. A maximum of 12 error numbers will be displayed. If a clean input screen is desired Shift F12 will cancel the transaction, return a clean input screen displaying any stored data and the message CANCEL ACCEPTED.



## WMS Principal Provider Subsystem, cont'd.

If there are no system detected errors, the accepted data and the accompanying system-generated data are returned on the line(s) below the input line.

Successful input transactions (message INPUT ACCEPTED) may be stored using Ctrl + F3. The message DATA SUCCESSFULLY STORED ON DATABASE acknowledges the stored transaction. The database is updated immediately; no batch update is required. Data that is not stored via Ctrl + F3 is not retained on the database.

Principal Provider stored data may be deleted or corrected using the following procedures:

**Deleting a Placement** – All data pertinent to a placement that was incorrectly entered may be deleted by entering DL in the Principal Provider Code field and entering the Principal Provider Number and Date of Service From Date and transmitting.

**Correcting Data** – Individual incorrect fields on a line of otherwise correct data may be corrected by entering the line number containing the error in the CL column and then entering the correct data in the appropriate field.

**Note:** A Date of Service From Date may be corrected only by using the Delete (DL) function and then re-entering the pertinent data with the correct Date of Service From Date.



## WMS Principal Provider Subsystem, cont'd.

### Inquiry

WMPPIQ – Principal Provider Inquiry Screen displays an historical record of Principal Provider information for an individual. Some data is not displayed when deletions and/or corrections are made. Since this inquiry is statewide, the transaction district is displayed on each line of data. The data is displayed in chronological order. Transactions with the most recent FROM date are displayed first.

The WMPPIQ screen is accessed by entering P for SUBSYSTEM, Q for FUNCTION and the CIN ON MMAMNU or by pressing Shift F5 from WMPPAQ – Principal Provider Audit Screen. The inquiry screen displays a maximum of 18 lines of data per screen page. Shift F keys 1, 2, and 3 may be used to page forward and backward if there are multiple pages.

Depressing Shift F5 returns WMPPAQ – Principal Provider Audit screen. Inquiry screens for CINS with Principal Provider Records (in Transaction District and Cross District) are accessed by entering desired CIN in NEXT CIN field.

### Audit

WMPPAQ – Principal Provider Audit Screen, displays a record of all transactions ever stored for an individual including those transactions that were later deleted and/or changed. Similar to inquiry, the audit screens list transactions (which cannot be changed) in chronological order with the most recent FROM dates displayed first.

The WMPPAQ screen is accessed by entering P for SUBSYSTEM, A for FUNCTION and the CIN on WMAMNU or by pressing Shift F5 from WMPPIQ. Shift F keys 1, 2, and 3 may be used to page forward and backward if there are multiple pages. Depressing shift F5 returns WMPPIQ – Principal Provider Inquiry Screen. Audit screens for CIN with Principal Provider Records (in Transaction District and Cross District) are accessed by entering desired CIN in NEXT CIN field.

### PRINCIPAL PROVIDER DATA INPUT FORM

NAME	FOR MEDICAL ASSISTANCE MENU			FOR PRINCIPAL PROVIDER INPUT SCREEN									
	CLIENT ID.	CASE NUMBER	WORKER ID.	CL	PP	PROVIDER	DATES OF SERVICE		EXCEPTION		AVAILABLE AMOUNT		ERRORS
							FROM	THRU	T	FROM	AMT	FROM	
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													

SIGNATURES, WITH DATES, AS REQUIRED BY LOCAL DISTRICT

\_\_\_\_\_



## WMSMNU

### WELFARE MANAGEMENT SYSTEM MENU

USE APPROPRIATE SF KEY ( 1 - 24 ) OR INDICATE SELECTION NUMBER ^^ XMT ^

- |                                     |   |
|-------------------------------------|---|
| 01 PA / FS BUDGET CALCULATION       | 17 TIME LIMIT TRACKING MENU               |
| 02 MA BUDGET CALCULATION            | 18 AUTO SDX / WMS MENU                    |
| 03 STATISTICS                       | 19 CCRS MENU                              |
| 04 APPLICATION REGISTRY MENU        | 20 EEDSS HOST SYSTEM MENU                 |
| 05 DENIAL ENTRY (APP AND SVCS)      | 21 W4139R INQUIRY REPORT                  |
| 06 SIGN OFF                         | 22 DOMESTIC VIOLENCE MENU                 |
| 07 N – S DATA ENTRY & DISPOSITION   | 23 GIS MENU                               |
| 08 MAPPER APPLICATIONS              | 24 PA / FS & MA QUARTERLY REPORTING       |
| 09 SERVICES FULL DATA ENTRY         | 25 MEDICAL ASSISTANCE MENU                |
| 10 SERVICES UNDERCARE / MAINTENANCE | 26 SSA 40 QUARTER MATCHING                |
| 11 CLIENT NOTICES MENU              | 27 CIBIC MENU                             |
| 12 WMS CASE & INDIVIDUAL INQUIRY    | 28 EMPLOYMENT MENU                        |
| 13 SCR MENU                         | 29 IV / A – IV / D RESPONDENT INFORMATION |
| 14 RFI                              | 30 FAIR HEARING MENU                      |
| 15 BICS MENU                        | 31 MMIS INQUIRY MENU                      |
| 16 WMSMNU (MENU KEY)                | 32 IRCS MENU                              |



WMAMNU

DIST

DATE

MEDICAL ASSISTANCE SUBSYSTEM MENU

SUBSYSTEM

FUNCTION

CIN

CASE NO.

WORKER

PAY - IN  
START DATE

XMT

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^^^^^^^^

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SUBSYSTEMS :

P - PRINCIPAL PROVIDER

R - RESTRICTION / EXCEPTION

C - PREPAID CAPITATION

X - PAY - IN / EXCESS INCOME

FUNCTIONS:

I - INPUT

Q - INQUIRY

A - AUDIT



WMPPIN

**PRINCIPAL PROVIDER INPUT**

DATE 092615

PAGE 01 OF 01

CLIENT - ID AB12345A

NAME JOHN SMITH

CASE - NO M12345

CL	<u>DATE</u>	<u>DIST</u>	<u>WRKR</u>	PP	PROVIDER	DATES OF SERV EXCEPTION			AVAILABLE	AMT
						FROM	THRU	T FROM	AMT	FROM
	092615	29	M01							

NEXT CIN ^





WMPPIQ

**PRINCIPAL PROVIDER INQUIRY**

DATE 092615

PAGE 01 OF 01

CLIENT - ID AB12345A

NAME JOHN SMITH

CASE - NO M12345

CL	DATE	DIST	WRKR	PP	PROVIDER	DATES OF SERV		EXCEPTION	AVAILABLE	AMT
						FROM	THRU	T FROM	AMT	FROM
01	092615	29	M01	08	00314998	082215	082915		00666.97	082215
02	052115	29	M01	08	00314998	051215	051415		00292.46	051215
03	111014	29	M01	08	00314998	103114	110314		00760.00	103114

NEXT CIN ^



WMPPIN

**PRINCIPAL PROVIDER AUDIT**

DATE **092615**

PAGE **01** OF **01**

CLIENT - ID **AB12345A**

NAME **JOHN SMITH**

CASE - NO **M12345**

CL	DATE	DIST	WRKR	PP	PROVIDER	DATES OF SERV EXCEPTION		AVAILABLE	AMT
						FROM	THRU T FROM	AMT	FROM
01	092615	29	M01	08	00314998	082215	082915	00666.97	082215
	092615	29	M01	08	00314998	082215			
	091415	29	M01	08	00314998	082215	082815	00856.14	
02	052115	29	M01	08	00314998	051215	051415	00292.46	051215
03	111014	29	M01	08	00314998	103114	110314	00760.00	103114

NEXT CIN ^



**WMS**  
**Pay-In/Excess Income**  
**Subsystem**

SAMPLE





# WMS Pay-In/Excess Income Subsystem

## Pay-In/Excess Income

Allows tracking and reconciliation of amounts prepaid to the district by the recipient, may also be employed to maintain a record of all acceptable medical expenses used to meet an excess (spenddown).

- The Pay In is an optional plan for recipients, allows entry of Pay In amounts from one to six months.
- Based upon a reconciliation report, recipients who choose to participate in the Pay In are returned or credited unused payments.

Accessed off the main menu of WMS through screen 25, the following functions are allowable entries for the Pay-In/Excess Income Subsystem, Input and Inquiry:

<b>Input Screen</b>	(I)	Accessed to enter and store an initial Transaction, update or delete records already stored.
<b>Inquiry</b>	(Q)	Displays entries that have been accepted by WMS



## WMS Pay-In/Excess Income Subsystem, cont'd.

### Pay-In/Excess

#### Input

Pay-In/Excess Income data is entered on WMPXIN – Pay-In/Excess Income Input Screen. Access to WMPXIN is obtained by entering selection 25 from the WMS Main Menu and transmitting, X (PAY-IN/EXCESS INCOME) for SUBSYSTEM, I (INPUT) for FUNCTION, CIN, WORKER ID and PAY-IN START DATE (month/year).

If there is no prior stored Pay-In/Excess Income data, the WMPXIN screen is returned with only the system generated data listed below but no historical data. If prior data was stored, the WMPXIN screen displays the previously stored data on the transaction and input line, also displayed is the following system generated data.

CLIENT ID

NAME

APPLY MTH/YR

CTY (county code)

TX DT (Transaction Input Date)

WORKER ID

MTH/YR APPLIED

The following message is returned after successful (no errors) data entry and transmitting.

INPUT ACCEPTED. PRESS CTRL + F3 TO UPDATE. (SHIFT  
HELP TO START OVER)

If CTRL + F3 is pressed, the data is stored, and the message \*\*\*UPDATES HAVE BEEN COMPLETED\*\*\* is displayed with the stored data. The database is updated immediately. Data that is not stored via CTRL + F3 is not retained on the database.



## WMS Pay-In/Excess Income Subsystem, cont'd.

If the Menu key is pressed, the WMAMNU menu is returned to Subsystem Menu.

If there are system-detected errors, the cursor is returned to the error field blinking. ERRO #: followed by an error message. # .

### Inquiry

WMPXIQ – Pay-In Excess Income inquiry Screen displays the current and historical record of data for the date specified.

The WMPXIQ screen is accessed by entering X for SUBSYSTEM, Q for FUNCTION, CIN, WORKER ID and PAY-IN START DATE on WMAMNU and transmitting.



## Using the Pay-In Program

- Social Service Districts are required to offer individuals with excess income the opportunity to pre-pay to the district the amount by which their excess income exceeds the MA income standard (Pay-In program)
- Individuals must be informed of their option to use the Pay-In program
- The choice to use the Pay-In program must be documented in writing and kept in the case record
- Individuals who pay their excess to the LDSS and then do not receive an equivalent amount in MA covered services are entitled to a refund
  - LDSS may issue the credit in the form of a refund to the recipient or in the form of credit to the recipient's account in a subsequent excess income period
  - Districts must wait a sufficient amount of time before issuing the refund to ensure that no claims will be submitted after
- Once the individual has paid in the amount of their excess to the LDSS, they must receive services from MA providers in order for MA payment to be made. (Credits or Refunds will NOT be provided for covered services rendered to the recipient by Non-Participating providers after the individual has paid the amount of their excess to the LDSS)

## Differences between using the Pay-In Program and using Medical Expenses to meet a spenddown

- Individuals who have paid their liability to the district and subsequently incur expenses during the covered period for Non-covered Services are entitled to a refund (refund can be issued in the form of a refund to the client or in the form of credit to a future excess income period)



WMAMNU

DIST

DATE

MEDICAL ASSISTANCE SUBSYSTEM MENU

SUBSYSTEM

FUNCTION

CIN

CASE NO.

WORKER

PAY - IN  
START DATE

XMT

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SUBSYSTEMS :

P - PRINCIPAL PROVIDER

R - RESTRICTION / EXCEPTION

C - PREPAID CAPITATION

X - PAY - IN / EXCESS INCOME

FUNCTIONS:

I - INPUT

Q - INQUIRY

A - AUDIT





WMPXIQ

**PAY - IN / EXCESS INCOME INQUIRY**

DATE 02/14/15 PAGE 1

CLIENT ID AB12345A

NAME JOHN SMITH

CTY 01

INQUIRY PERIOD JANUARY 2015

<u>TX DATE</u>	<u>WRKR</u>	<u>TX TYPE</u>	<u>ASSOC CIN</u>	<u>F I</u>	<u>EXCESS AMOUNT</u>	<u>PAY - IN AMOUNT</u>	<u>BILLS PAID</u>	<u>BILLS INCURRED</u>	<u>BALANCE</u>	
012815	M05	P			20.00	20.00			0.00	
<u>C / D LINE #</u>	<u>TX DATE</u>	<u>CTY CD</u>	<u>WRKR</u>	<u>BILL TYPE</u>	<u>BILL AMOUNT</u>	<u>DATE OF SERVICE</u>	<u>PROV TYPE</u>	<u>MTH / YR APPLIED</u>	<u>FA STAT</u>	<u>XMIT</u>



WMPXIQ

**PAY - IN / EXCESS INCOME INQUIRY**

DATE 02/14/15

PAGE 1

CLIENT ID AB12345A

NAME JOHN SMITH

CTY 01

**INQUIRY PERIOD JANUARY 2015**

<u>TX DATE</u>	<u>WRKR</u>	<u>TX TYPE</u>	<u>ASSOC CIN</u>	<u>F I</u>	<u>EXCESS AMOUNT</u>	<u>PAY - IN AMOUNT</u>	<u>BILLS PAID</u>	<u>BILLS INCURRED</u>	<u>BALANCE</u>	
012815	M05	P			18.00	18.00	2.00		0.00	
<u>C / D LINE #</u>	<u>TX DATE</u>	<u>CTY CD</u>	<u>WRKR</u>	<u>BILL TYPE</u>	<u>BILL AMOUNT</u>	<u>DATE OF SERVICE</u>	<u>PROV TYPE</u>	<u>MTH / YR APPLIED</u>	<u>FA STAT</u>	<u>XMIT</u>
	012815	01	50	P	2.00	010215	888	0115	N	

**ADMINISTRATIVE DIRECTIVE**

**TRANSMITTAL:** 96 ADM-15

**TO:** Commissioners of  
Social Services

**DIVISION:** Health & Long  
Term Care

**DATE:** August 13, 1996

**SUBJECT:** Excess Income Program Clarifications/Prepayment  
of Client Liability (Pay-In) Program

**SUGGESTED  
DISTRIBUTION:**

Medical Assistance Staff  
Staff Development Coordinators  
Accounting Supervisors

**CONTACT  
PERSON:**

1-800-343-8859  
Medical Assistance:  
Upstate - Ann Hughes, ext. 3-5501  
New York City - 212-383-2512  
Fiscal:  
Bureau of Local Financial Operations,  
Regions 1 through 4 - Roland Levie, ext. 4-7549  
Region 5 - Marvin Gold, 212-383-1733

**ATTACHMENTS:**

Available On-Line:  
Attachment I - Excess Income Case Examples  
Attachment II - Excess Income Desk Aid  
Attachment III - Optional Pay-In Program For  
Individuals With Excess Income  
Attachment IV - Pay-In Case Examples  
Attachment V - Required Format For Pay-In Plans  
Attachment VI - Mandatory Pay-In Notices

**FILING REFERENCES**

Previous ADMs/INF's	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
96 ADM-12		360-4.8 (c)	366 (2) (b);	MARG pp	GIS
91 ADM-11			Chapter 81	223-231	95 MA/025
87 INF-19			of the Laws		
87 ADM-4			of 1995;		95 LCM-131
			SSA 1903 (f)		
			42CFR		
			435.831		
			435.914		

I. **PURPOSE**

This Administrative Directive (ADM):

- clarifies the treatment of the retroactive eligibility period and the use of medical expenses when determining countable income for purposes of eligibility for Medical Assistance (MA); and
- informs social services districts of required action as a result of the enactment of Chapter 81 of the Laws of 1995, which established a statewide program for prepayment of the client liability under the Excess Income program.

II. **BACKGROUND**

Federal regulation 42 CFR 435.831 provides that, in determining an individual's eligibility for Medical Assistance (MA), if countable income exceeds the income standard, the State must deduct from income medical expenses that are not subject to payment by a third party. Once deduction of medical expenses reduces excess income to the income standard, the individual is eligible for MA.

A. **Retroactive Eligibility Period and Use of Medical Expenses**

42 CFR 435.831 formerly provided that states must use a prospective period of not more than six months to compute income. Thus, when determining eligibility for the three month retroactive period, it was always considered a discrete period.

87 ADM-4 set forth guidelines for use by social services districts in applying medical expenses toward an excess income liability. This ADM provided that paid expenses in excess of an individual's monthly liability could be used to obtain additional months of appropriate coverage for up to six months at a time. Unpaid expenses in excess of the individual's liability and not payable by the MA program could also be used to obtain additional months of coverage, as long as the expense remained viable and had not previously been used to obtain eligibility.

Effective March 14, 1994, the Health Care Financing Administration amended 42 CFR 435.831 to provide states the option to include in the period over which income is computed all or part of the three-month retroactive period. The amendment also clarified the appropriate use of paid and unpaid medical expenses to reduce income to the income standard, requiring changes in the Department's excess income policy.

B. Mandatory Pay-In Program

The Omnibus Budget Reconciliation Act of 1990 amended 42 U.S.C. 1396b(f) to allow, at state option, the prepayment of an individual's income liability to the state agency. Formerly, Section 366(2)(b) of the Social Services Law (SSL) authorized social services districts with Department-approved prepayment plans to permit an otherwise eligible individual whose income exceeded the income standard to become eligible for MA by paying his/her income liability directly to the social services district. Five social services districts operated approved Pay-In programs under this provision.

Chapter 81 of the Laws of 1995 amended SSL Section 366(2)(b) to require all social services districts to offer excess income recipients the option to participate in the Pay-In program.

III. PROGRAM IMPLICATIONS

A. Retroactive Eligibility Period and Use of Medical Expenses

The change in federal regulations allows income to be computed over a period of not more than six months, which may include all or part of the three-month retroactive eligibility period. The retroactive period begins no earlier than the first month in the period in which the individual received covered services and, when combined with prospective months, can be no longer than six months. In some circumstances, combining all or part of the retroactive period with prospective months of eligibility may be more beneficial to the individual.

In determining medical expenses to be deducted from countable income during a period, social services districts must include all paid or unpaid medical expenses incurred during such period, to the extent that the expenses have not been deducted previously in establishing eligibility. As explained more fully in Section IV.A.2.b. of this ADM, paid expenses in excess of a client's liability generally are not carried forward from one period to the next. Viable unpaid expenses may be carried forward from a previous period when the individual's eligibility was established in such previous period without deducting all such incurred, unpaid expenses. However, viable unpaid expenses are no longer carried forward from a period in which a spenddown liability was not met.

B. Mandatory Pay-In Program

Allowing individuals with excess income to obtain MA eligibility by prepaying their excess income liability to the social services district has several advantages:

- o improves access to medical care for recipients by helping to ensure timely authorization of MA eligibility;
- o provides recipients with a simplified procedure for achieving and maintaining eligibility;

- o reduces processing time currently associated with excess income cases;
- o reduces program costs by permitting purchase of necessary care and services at MA rates, rather than private pay rates; and
- o eliminates inappropriate program costs due to inadvertent or fraudulent provider billing of medical expenses which have been used to establish eligibility.

Social services districts must operate a Pay-In program in accordance with a plan approved by this Department. Only those plans meeting the requirements outlined in Section IV.B. of this ADM will be approved. Upon approval of the district's Pay-In plan, the district must offer all excess income recipients the option of participating in the Pay-In program on a voluntary basis.

Administrative expenses associated with social services districts' operation of a Pay-In program may be exempt from the State share cap on administrative costs, pursuant to an approved local plan submitted in accordance with 96 ADM-12.

**IV. REQUIRED ACTION**

Department regulation 360-4.8(c) and 87 ADM-4 detail requirements for the use of paid or incurred expenses for necessary medical or remedial care, not subject to payment by a third party, to reduce excess income. This includes medical expenses paid for or incurred by public programs of the State or any of its political subdivisions, in accordance with 91 ADM-11. Once incurred medical expenses reduce income to the MA income standard, the individual is eligible for MA; however, no MA payment will be made for those incurred medical expenses used to establish eligibility.

A. Income Periods and Use of Medical Expenses

**1. Accounting Periods**

In determining an individual's eligibility, districts must use a period of not more than six months to compute income (an accounting period). More than one accounting period may be used. Federal regulations continue to allow districts to treat the entire retroactive period as one three-month period, or divide the retroactive period into monthly periods. In addition, the amendment to 42 CFR 435.831 now allows districts to add all or part of the retroactive period to the first prospective months, for a combined period not to exceed six months.

## 2. Determining Deductible Expenses

### a. Required Deductions

In determining medical expenses to be deducted from income, federal regulations provide that the following must be included:

- (i) expenses incurred for Medicare and other health insurance premiums, deductibles or other coinsurance charges;
- (ii) expenses incurred for necessary medical and remedial services that are recognized under State law but are not covered by MA; and
- (iii) expenses incurred for necessary medical and remedial services that are covered under the MA program.

(Under the provisions of 18 NYCRR 360-4.8(c) these expenses must be deducted in the order listed above.)

### b. When Expenses Are Used

#### (i) Paid Expenses

A **paid** expense must be deducted from income in the accounting period in which it is paid. This means that a paid expense in excess of the individual's liability cannot be used to provide more than six months of coverage (the maximum period over which income can be computed). In addition, once a six month liability is met, and full coverage provided, any subsequent expenses paid by the recipient during such period are not carried forward to the next excess income period.

An exception is made for expenses incurred and paid in the three-month retroactive period. When no part of the retroactive period is included in the first prospective accounting period, expenses incurred and paid during the retroactive period which have not been used previously to establish eligibility can be deducted from income in the first prospective accounting period.

#### (ii) Unpaid Expenses

An **unpaid** expense must be deducted from income in the accounting period in which it is incurred. In addition, if the individual's liability is met in that period without deducting all incurred, unpaid expenses, the excess unpaid expenses for services not covered by the MA program may be carried forward and deducted from income in a subsequent accounting period.

Unpaid expenses from the retroactive and pre-retroactive accounting periods may be carried forward and deducted from income as long as they remain viable and have not previously been used to establish eligibility.

In both these situations (excess unpaid expenses incurred in a prior accounting period, and unpaid, unused, retroactive or pre-retroactive expenses), the requirement to carry such expenses forward ends when the individual has an excess income liability that is not met, or the individual no longer has an excess income liability. This is a change from previous excess income policy, which allowed the balance of unpaid expenses which were not used to establish eligibility to be carried forward as long as the expense was viable.

**ATTACHMENT I** of this ADM provides case examples to clarify these requirements. **ATTACHMENT II** was developed as a Desk Aid to outline excess income policy.

B. Mandatory Pay-In Program

Social services districts are required to offer individuals with excess income the opportunity to reduce their excess income by pre-paying to the district the amount by which their income exceeds the MA income standard. In establishing a Pay-In program, districts must follow the guidelines provided in Department regulation 360-4.8(c)(4) and outlined in this section.

1. **Pay-In Program Requirements**

a. **Client Option**

Participation in the Pay-In program is optional on the part of the recipient. Currently, A/Rs must be provided with the DSS-4038, "Explanation of the Excess Income Program," whenever an excess income liability is determined. In addition, upon approval of a district's Pay-In plan, the district must provide **ATTACHMENT III** (or an approved local equivalent form) to these individuals, which explains the pay-in option. The individual's election of the pay-in option must be documented in writing and retained in the case record.

It is recommended that districts screen potential Pay-In participants to ensure sufficient medical expenses each month to warrant their participation. Individuals who pay their excess income to the district and then do not receive MA covered services cannot receive refunds until sufficient time has elapsed to establish that no claims have been submitted. Individuals without sufficient medical expenses to meet their excess income liability should not be encouraged to participate.



**b. Pay-In Accounts**

The district must establish a special account to safeguard the amounts paid to the district by the individuals. Such amounts must not be retained in interest-bearing accounts.

**c. Pay-In Periods**

The individual may elect to pay-in for periods of one to six months. When the pay-in period is longer than one month, the individual may pay the full excess income amount at the beginning of the period, or may pay in monthly installments.

For pay-in periods of less than six months, full coverage will not be authorized; instead, outpatient coverage (MA Coverage Code 02) will be authorized. Please note, however, that outpatient coverage will be authorized for a particular month only after the excess income liability has been met for that month. When the individual pays the full excess income liability for a six month period, full coverage (MA Coverage Code 01) will be authorized for that period.

**d. Combining Paid/Incurred Medical Expenses With Pay-In Amounts**

- (i) In order to obtain coverage, the participant must pay to the social services district the amount by which his or her net available income exceeds the MA income standard for the appropriate period. In determining this amount, the district must deduct from income any necessary medical expenses incurred during the period which are not payable by the MA program. (See **ATTACHMENT IV**, Example 1.)
- (ii) If the individual has paid his/her liability to the district and subsequently incurs expenses during the covered period for services not covered by the MA program, the district must either refund to the recipient the amount of the medical expense from the recipient's account, or may credit the amount to the recipient's account in a subsequent excess income period. (See **ATTACHMENT IV**, Example 2.)

**NOTE:** Once the individual has paid in the amount of his/her excess income to the social services district, he/she is treated like any other MA recipient. Thus, the recipient must receive services from MA providers in order for MA payment to be made. Credit or refunds will not be provided for covered services rendered to the recipient by nonparticipating providers.

**e. Reconciliation of Pay-In Accounts**

Districts must periodically reconcile the amount in the MA recipient's account with the amount of MA payments made on the recipient's behalf. The amount in the account, minus any amount to be refunded pursuant to paragraph d.(ii) above, must be compared to the MA payments made for services provided during the covered period. Any unused pay-in amounts must be refunded to the recipient or credited to a subsequent excess income period. (See **ATTACHMENT IV**, Example 3.)

**NOTE:** When reconciling the individual's Pay-In account, social services districts must take into consideration any off-line payments made on behalf of a participant, since these payments will not be reflected in the Adjudicated Claims history report.

**2. Requirements for District Plans**

Chapter 81 of the Laws of 1995 requires that social services districts submit to the Department no later than February 1, 1996, a plan for the operation of a Pay-In program. The plan must include a detailed description of how the district will administer the program, enroll recipients, safeguard monies in recipient accounts, reconcile accounts with payments made to MA providers, and refund or credit recipients for overpayments. **ATTACHMENT V** contains the required format for submitting this plan. This format was provided to social services districts in Local Commissioners Memorandum 95 LCM-131, dated December 6, 1995.

Plans must be submitted to:

New York State Department of Social Services  
Division of Health and Long Term Care  
40 North Pearl Street  
Albany, NY 12243

The Department must approve, disapprove, or request modification of a social services district's Pay-In plan, within 90 days of receipt of the plan. The Department has reviewed the plans of those districts currently operating approved Pay-In programs, and has advised such districts of any necessary modifications.

**3. Notice Requirements**

New client notices have been developed to accommodate the requirements of the Pay-In program. These notices are included as attachments to this ADM.

To inform recipients of refunds or credits to their Pay-In accounts due to medical expenses not covered by the MA program, use "Notice of Credit Due to Uncovered Expenses," **ATTACHMENT VI (a)**, or "Notice of Refund Due to Uncovered Expenses," **ATTACHMENT VI (b)**.

To inform recipients of the results of reconciliation of their accounts with the MA claims paid on their behalf, use "Notice of Credit Due to Review of Medical Assistance Claims," **ATTACHMENT VI (c)**, or "Notice of Refund Due to Review of Medical Assistance Claims," **ATTACHMENT VI (d)**.

These notices must be manually reproduced until they become available as Department forms.

In addition, social services districts may elect to discontinue recipients who fail to pay-in for three or more consecutive months. For districts which exercise this option, discontinuance language has been programmed in to the Client Notices Subsystem (CNS) as follows:

This is because you elected to pay your excess income to this agency in order to receive Medical Assistance coverage. You have not paid your excess income to this agency for three or more consecutive months. Also, you have not submitted paid or unpaid medical bills that are equal to or more than the amount your income is over the income limit.

If you incur medical bills in the amount of your excess income in the future, you may reapply.

This language will be generated by using reason code E22.

#### 4. **Claiming Refunds**

Money received by the district should be deposited into the TA-53 Social Services trust and agency account. For CAMS districts using the Cash Receipt subsystem these payments may be entered into Cash Receipts with a Revenue Reason Code of 403 (TA-53). All other districts must perform the Cash Receipt posting function manually. No monies would be reported to the State at the time the payment is received from the client.

As noted previously, districts must periodically (at least yearly) reconcile the balance in the MA recipient's TA-53 account with the amount of MA payments made on the recipient's behalf. A refund of the TA-53 balance to the recipient or account credit toward subsequent periods is necessary if the recipient has paid in more than the amount of MA claims paid out by the local district.

If the recipient receives services from MA providers for a particular period then either all or part of the pay-in amount (depending on the amount of MA services received) should be applied to the cost of the MA service. When this happens, for CAMS districts the payments should be transferred out of the TA-53 account and into the A-1801 Repayment of Medical Assistance account by a CR modification. These instructions apply to CAMS districts with Cash Receipts functions. For more information, please refer to Chapter 2, Cash Receipts, of the Cash Management Procedural Manual. All other districts should manually perform this function. The payments should be displayed on the refund roll as Medical Assistance pay in.

The MA pay-in amount received and applied to MA expenditures must be claimed as a refund on the Schedule E (Computation of Federal and State Aid on Medical Assistance, DSS-157) in the month in which the payment is applied to the MA expenditure. The refunds should be reported in columns 2 and 7 (FP Other) on line 27 (Other) of the Schedule E.

If the refunds are related to enhanced funding categories such as Native Americans, Mental Hygiene Releasees or Refugees/Entrants, then the refunds should be carried forward to either the RF-3 (Adjustment Claim for Additional State Aid on Expenditures 100% Reimbursable) or the RF-6 (Monthly Claim for Reimbursement and Statistical Report Assistance to Resettled Refugees). Please review the Fiscal Reference Manual, Volume 2, Chapter 3 for Schedule E, RF-3, and RF-6 claiming instructions.

If the reconciliation determines a balance is due to the client a check should be produced for the balance. Upon receipt of a manually prepared DSS-3209, or worker and supervisor signed local district authorization form, Accounting should initiate a check from the client's TA-53 account. In lieu of payment, the client account may be credited for subsequent excess income periods.

#### **5. Administrative Expenses**

The local social services districts will claim the costs of administering this program as F-4 functional expenditures on the Schedule D-4, Calculation of Medical Assistance Eligibility Determination/Authorization/Payments Cost Shares-DSS-2347-B2. Instructions for completing the Schedule D-4 are found in Chapter Eleven of the Local Cost Allocation Manual - Bulletin 143b.

As stated in Section III, Program Implications, administrative expenses associated with the Pay-In program are exempt from the State share cap on administrative costs. To receive this exemption, social services districts must submit a plan for exemption to the Bureau of Local Financial Operations for approval, in accordance with 96 ADM-12.

#### **V. SYSTEMS IMPLICATIONS**

The Pay-In/Excess Income Subsystem, which provides the mechanism for district tracking of pay-in amounts and paid/incurred bills used by participants to obtain eligibility, became available for local district use on May 6, 1996. Training on the Subsystem was provided to all local districts during April and May, 1996.

Districts electing to have this Department conduct an annual reconciliation of Pay-In participants' paid claims with pay-in amounts must make the appropriate entries in the Subsystem. The first scheduled reconciliation for Pay-In program participants with entries in the Subsystem is scheduled for early spring, 1997.

**Date:** August 13, 1996

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**VI. EFFECTIVE DATE**

This Directive is effective August 1, 1996. Chapter 81 of the Laws of 1995 required social services districts to submit a plan for operating a Pay-In program to the Department no later than February 1, 1996.

\_\_\_\_\_  
Martin J. Conroy  
Acting Deputy Commissioner  
Division of Health and Long Term Care

## EXCESS INCOME EXAMPLES

1. Combining Retroactive Period With First Prospective Period

Mrs. Spencer, age 67, applies for MA in May and is determined to have monthly excess income of \$160 and a six month excess of \$960. She presents the following bills:

February - \$900 inpatient hospital bill (paid)  
May - \$150 physician's bill (unpaid)

She anticipates ongoing medical expenses for a chronic condition.

- (a) In this example, if the retroactive period were treated as a distinct period, Mrs. Spencer would not be eligible in the retroactive period because her hospital bill did not equal or exceed her six month liability and there were no other covered services received in the period. Because the bill was paid, and was not in excess of her liability, it cannot be deducted from income in a subsequent accounting period. Therefore, she is also not eligible for outpatient coverage in May, because her medical expenses do not equal or exceed her monthly liability for that month. Mrs. Spencer may or may not be eligible in subsequent months, depending on the amount of medical expenses she incurs.

However, if the retroactive period were combined with the first prospective period, the paid inpatient bill can be combined with the May physician's bill of \$150. Mrs. Spencer has now met her six month liability. She can be given full coverage for February through July. Thus, the balance of the physician's bill not used to establish eligibility (\$90) is payable by MA, up to the MA rate, and any additional covered expenses incurred by Mrs. Spencer in May, June or July are payable by MA.

- (b) Assume Mrs. Spencer's February hospital bill was **unpaid** when she applied in May and the physician bill was **paid**. She would still not be eligible in the retroactive period, because the bill did not meet her liability. However, because this is a viable, unpaid medical expense that has not been used to establish eligibility, it can be carried forward and deducted from income in a subsequent accounting period. In this situation, it is more advantageous to Mrs. Spencer to treat the retroactive period as a distinct period.

In May, the agency uses the paid physician's bill of \$150 and the unpaid hospital bill of \$900 to meet the six month excess income liability. Any additional covered expenses incurred by Mrs. Spencer from May through October are also payable by MA.

2. Using Paid Bills To Establish Eligibility

Ms. Stuart is in receipt of Social Security Disability Benefits. Her monthly excess income is \$27 and her six month excess is \$162. She routinely submits expenses to meet her liability each month and is given outpatient coverage. In June, she goes to the chiropractor and incurs a \$193 bill which she pays from her savings. The agency uses the paid bill in June to meet Ms. Stuart's six month liability of \$162 and provides full coverage from June through November. Although there is a balance left on the paid bill of \$31, it may not be used to establish eligibility in any additional months, since a paid bill must only be deducted from income in the accounting period in which it is paid.

3. Using Unpaid Expenses To Establish Eligibility

Mr. O'Hare files a new application for MA in January, 1997 on behalf of himself, his wife and their fourteen year old son. Mr. O'Hare is in receipt of UIB and meets the categorical requirements for ADC-U eligibility. The family is determined to have monthly excess income of \$69, and a six month excess of \$414. He presents the following bills:

September, 1996 - \$250 dental bill (unpaid)  
October, 1996 - \$59 emergency room (paid)  
                  - \$60 x-ray (unpaid)  
November, 1996 - \$100 physician's bill (unpaid)  
December, 1996 - \$15 pharmacy bill (unpaid)  
January, 1997 - \$75 dental bill (unpaid)

In determining eligibility for October, the first month of the retroactive period, the agency uses the \$59 paid expense and \$10 of the viable, unpaid September bill to meet the October income liability. The balance of the September bill (\$240) is used to establish eligibility for outpatient coverage in November, December and January, allowing the unpaid expenses from those months to be paid by MA. The balance of \$33 from the September bill, which was not used to establish eligibility, is credited toward the income liability in February. If the O'Hare's incur medical expenses equal to \$36 in February (\$69 minus \$33) they may be given outpatient coverage in February. If they do not incur expenses sufficient to meet the February income liability, the \$33 credit is **not** available in any subsequent months.

However, if Mr. O'Hare were to pay the \$250 dental bill in a subsequent accounting period, any amounts not previously used to establish eligibility would be deducted from income as a current payment. In the example above, \$33 could be deducted from income in the period in which the payment was made.

**OPTIONAL PAY-IN PROGRAM FOR INDIVIDUALS  
WITH EXCESS INCOME**

Individuals whose income exceeds the Medical Assistance income limit may still receive help with medical bills. The form DSS-4038, "EXPLANATION OF THE EXCESS INCOME PROGRAM" explains that if you bring in or send us your medical bills each month which are equal to or more than the amount of your excess income, you may receive coverage for any other medical expenses you incur from a Medical Assistance provider in that month. Explained below is another way you can get Medical Assistance coverage.

Instead of bringing or mailing in your medical bills each month, you can pay to this agency the amount of your income that is over the limit. If you decide to pay this money to us, you will be given outpatient coverage for the month you are paying for, and will not have to wait until you incur a medical bill. If you pay a total of six months of excess income, you will be given outpatient and inpatient coverage for that six month period. Once you are given coverage, you can use your Medical Assistance card to obtain services from your doctor or other medical provider. You must be sure the provider accepts payments from the Medical Assistance program before you receive the service.

If you pay your excess income to this agency, and then get or pay a bill for medical services that Medical Assistance does not cover (for example, chiropractor's service), we will give you a refund or we will give you a credit toward the next available uncovered month. You must bring in or send to us the paid or unpaid bill in order to get a credit or refund.

\* Remember, we will not pay for or give credit for any bill or portion of a bill that is covered by **Medicare** or other health insurance that you have.

If you decide to pay your excess income to the agency, from time to time we will review the amount of all the claims we have paid for you, and compare this amount to the amount you have paid. If you have paid more than you should have, we will decide to give you a refund or give you credit for coverage in another month. We will make this decision based on your circumstances.

You should consider the following before deciding to take part in the PAY-IN PROGRAM.

1. Unless you know that you will need medical services during a month, it is not to your benefit to pay us your excess income that month.
2. If you pay your excess income for a period and then do not use your Medical Assistance card, it may take at least a year for us to give you a refund or credit. This is because we must wait to see if any claims have been paid for you for that period.



3. If you decide you want to pay your excess income to this agency, you may do so every month, or only in those months that you know you will need medical services. If you want, you may pay us for more than one month at a time, up to six consecutive months. However, if you decide to pay your excess income and then do not make a payment to us for three consecutive months, you **may** receive a notice of our intent to close your case. You may reapply for Medical Assistance if you incur or expect to incur medical expenses at least equal to your excess income and wish to make a payment or submit bills to receive coverage.

**YOUR MEDICAL ASSISTANCE EXAMINER CAN ANSWER ANY QUESTIONS YOU HAVE AND HELP YOU DECIDE IF PAY-IN IS RIGHT FOR YOU.**

## PAY-IN EXAMPLES

1. Mr. Kelly, age 65, applies for MA in August, 1996, and is determined to have \$65 in excess monthly income. He has outstanding medical bills in June and July for which he is seeking coverage. Since he anticipates ongoing medical expenses, Mr. Kelly elects to participate in the Pay-In program. He has documented the following medical expenses:

June:           \$19 prescriptions (paid)  
                  \$50 chiropractor (unpaid)  
                  \$85 physician (of which he has paid \$50)

July:           \$27 prescriptions (paid)  
                  \$65 physician (unpaid)

The bills Mr. Kelly paid in June (total \$69) exceed his excess income liability and he is given outpatient coverage (Coverage Code 02) for June. His physician, who is a participating provider, is sent the DSS-3183, informing him that he may bill MA for the balance of the June bill, up to the Medicaid rate. Because Mr. Kelly paid \$4.00 more than necessary, he can be given a credit to reduce his July excess income.

In July, the \$4 credit and the \$27 paid prescription bill are deducted from Mr. Kelly's excess income liability, leaving a balance of \$34. The unpaid chiropractor bill for services in June is still viable. Since this bill was not previously used to establish eligibility, \$34 is applied toward the remaining liability to establish eligibility for outpatient coverage in July. Mr. Kelly should advise his physician that he is eligible for MA in July.

Mr. Kelly has not yet incurred any expenses in August but has several medical appointments later in the month for which he would like coverage. His worker applies that portion of the June chiropractor bill which was not previously used to establish eligibility (\$16) to reduce Mr. Kelly's excess income for August. Mr. Kelly pays \$49 to the agency and is given outpatient coverage for the month of August.

2. Mr. Kelly pays \$65 each month to the agency and is given outpatient coverage. In November, he returns to the chiropractor and incurs a bill for \$45, which he submits to the agency. Because the district's policy is to give refunds in this situation, the worker follows appropriate procedures to issue a \$45 refund to Mr. Kelly. (The district could also opt to give a credit toward the next excess income period. In this case, Mr. Kelly would be given a \$45 credit in his Pay-In account for December and would only need to pay \$20 to obtain coverage for that month.)

3. In January, 1998, the district performs a reconciliation of Mr. Kelly's pay-in account for the month of January, 1997. The district uses a report of MA claims paid for Mr. Kelly for services incurred during that month and finds that the total MA claims paid was only \$50.00. Since Mr. Kelly paid \$65.00 to the district that month, the district must either refund \$15.00 to Mr. Kelly or give him a credit of \$15.00 toward reducing excess income in a subsequent month.

**NOTE:** When a credit is provided to a recipient because of a non-covered expense incurred after the recipient has paid in for the period, and in the month of credit the individual does not obtain eligibility (i.e., he/she does not pay-in the balance of the liability or present bills equal to the balance), under excess income rules that credit is not available in any subsequent months. However, when a district is reconciling the amount a recipient has paid to the district with the amount of MA claims paid on the recipient's behalf, and the recipient has not received services equal to the amount paid, any credit is not lost with a break in eligibility. The district must continue to provide the credit until it is used or must issue a refund to the individual.

Pay-In Program Plan

**I. Identifying Information:**

- A. District Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- B. Contact Person: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_

**II. Organizational Units Involved in Pay-In Program:**

- A. Organizational unit with overall responsibility for the program:  
 \_\_\_\_\_
- B. List other organizational units responsible for tasks associated with the program and specify the task (i.e., collection of payments; reconciliations; issuing refunds, etc.):

Unit Name	Task
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**III. Administration of the Pay-In program:**

- A. Obtaining Recipients' Voluntary Participation
  - 1. Recipients are informed of the option to pay-in excess income to the District by:
    - \_\_\_\_\_ State Mandated Notice
    - \_\_\_\_\_ Local Equivalent Notice (A copy of the notice is attached to this plan)
  - 2. Describe procedures for obtaining and documenting recipients' voluntary participation. Attach additional pages as needed.

Pay-In Program Plan

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2. Procedures for obtaining and documenting voluntary participation (continued):

B. Collection Procedures

1. Payments may be made by mail or in person, in the form of cash, checks or money orders. Describe the procedures for collecting and safeguarding recipients' payments, including procedures for dealing with checks returned for insufficient funds. (Note: Districts are not required to provide coverage until clearance of a check by the bank.) Attach additional pages as needed.



Pay-In Program Plan

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2. Recipients who pay in to the District to obtain eligibility and subsequently incur expenses which are not covered by the MA program are treated as follows:

\_\_\_\_\_ given a refund, up to the amount paid in

\_\_\_\_\_ given credit toward their excess income liability in a subsequent budget period

\_\_\_\_\_ on a case-by-case basis, given a refund or a credit as appropriate.

3. Recipients are informed of the decision to provide a refund or a credit and the amount thereof by:

\_\_\_\_\_ State Mandated Notice

\_\_\_\_\_ Local Equivalent Notice (A copy of the notice is attached to this plan)

D. MA Authorization Procedures

Describe the process for ensuring timely authorization of MA Coverage Code 02 (Outpatient) when monthly excess is met, or 01 (Full Coverage) if six month excess is met. Attach additional pages as needed.

Pay-In Program Plan

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E. Reconciliation of recipients' payments with MMIS adjudicated claims

1. Reconciliation of the recipient's prepayment account with MA claims paid on his/her behalf is conducted at least annually, at intervals of \_\_\_\_\_ months.

2. The Department's automated reconciliation process will be used to determine the amount of overpayment, if any:

\_\_\_\_\_ Yes

\_\_\_\_\_ No

If no, describe the process to be used. Attach additional pages as needed.

SAMPLE



Pay-In Program Plan

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3. Recipients who pay in to the District more than the amount of MA payments made on their behalf for the budgeting period are treated as follows:

\_\_\_\_\_ refunded the difference between the total amount of MA claims paid and the amount paid-in to the District.

\_\_\_\_\_ given credit toward their excess income liability in a subsequent budget period

\_\_\_\_\_ on a case-by-case basis, given a refund or a credit as appropriate.

4. Recipients are informed of the decision to provide a refund or a credit and the amount thereof by:

\_\_\_\_\_ State Mandated Notice

\_\_\_\_\_ Local Equivalent Notice (A copy of the notice is attached to this plan)

F. Reporting of Pay-In amounts to the Department

Pay-In amounts, minus any refunds and/or credits are reported to the Department on Schedule E for purposes of distribution adjustment of federal, State, and local shares of Medicaid expenditures.

G. Other

Submit any additional information which will help in evaluating the plan, such as flow charts, or internal forms and reports.

Pay-In Program Plan

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Assurances/Signature

Pursuant to Chapter 81 of the Laws of 1995, \_\_\_\_\_ hereby submits this Plan for the operation of a Pay-In of Client Liability program, which allows eligible Medical Assistance (MA) recipients to reduce their excess income by pre-paying to the District the amount by which their income exceeds the MA income standard. We agree to administer the program in accordance with all applicable federal and State laws and regulations and provisions of this Plan.

We assure that we will:

- (1) upon approval of the State Department of Social Services (SDSS), have in effect and operation a Pay-In of Client Liability Program which:
  - (i) meets the requirements of applicable federal and State law and regulations, and is designed to improve access to medical care for recipients and reduce program expenditures; and
  - (ii) provides all MA excess income recipients the option of participating in the program on a voluntary basis and allows election or rejection of the pay-in option on a monthly basis; and
  - (iii) allows a combination of paid/incurred expenses and pay-in amounts to be used to obtain eligibility; and
  - (iv) ensures that no MA funds are expended for the individual prior to the individual meeting his/her excess income liability; and
  - (v) allows the use and disbursement of pay-in amounts for services not covered under the State plan; and
  - (vi) ensures that amounts paid to the District by recipients are safeguarded in a separate non-interest bearing account; and
  - (vii) provides for at least annual reconciliation of the recipient's pay-in amounts with the amount of MA payments made on the recipient's behalf, and provides for a refund of unused pay-in amounts or a credit of the unused amounts in a subsequent excess income period.

Signature of Local Social Services Commissioner: \_\_\_\_\_

Date: \_\_\_\_\_