STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 08 OHIP/ADM-4

TO: Commissioners of Social Services

DIVISION: Office of Health Insurance Programs

DATE: May 6, 2008

SUBJECT: Renewal Simplification for Medicaid and Family Health Plus Recipients

SUGGESTED DISTRIBUTION:
Medicaid Staff
Fair Hearing Staff
Legal Staff
Staff Development Coordinators
Temporary Assistance Staff

CONTACT PERSON:
Bureau of Local District Support
Upstate: (518) 474-8887
NYC: (212) 417-4500

ATTACHMENTS:
Attachment I. Income Attestation Desk Aid
Attachment II. Notice of Intent to Change Medicaid Coverage to Family Health Plus
Attachment III. Examples
Attachment IV. Explanation of the Income and Resource Documentation Requirements for Medicaid

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
03 OMM/ADM-2 04 OMM/ADM-6			366-a(5)(d) and (e) 369-ee(2)(d)		GIS 01 MA/24

I. PURPOSE

This Administrative Directive (ADM) advises Local Departments of Social Services (LDSS) of the provisions of Chapter 58 of the Laws of 2007 regarding attestation of income and residence at renewal for certain Medicaid recipients and all Family Health Plus (FHPlus) recipients.

II. BACKGROUND

Currently, to redetermine eligibility at renewal for Medicaid and FHPlus, recipients are required to document income and residence, if the address has changed since the last eligibility determination. Districts were previously notified, in GIS 01 MA/024, that unless a district had reason to believe that a recipient no longer resided at the address specified, a recipient's receipt of the renewal form was sufficient documentation of current residence.

With the passage of Chapter 58 of the Laws of 2007, community Medicaid recipients who are not seeking coverage of long-term care services, recipients who are exempt from a resource test and all FHPlus recipients will be allowed to attest, at renewal or any time after initial application, to the amount of their income and to their residence, even if their address has changed since their last eligibility determination. Also included are recipients of the Medicare Savings Program (MSP) and the Family Planning Benefit Program (FPBP). Participants in the Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD) and the Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal and Prostate may attest to income and residence if they are not seeking coverage for long-term care services. This legislation will further simplify the documentation requirements for re-determining eligibility for many Medicaid and FHPlus recipients. It is expected that this easement will result in greater retention of recipients at renewal.

In lieu of income documentation, local social services districts must verify the accuracy of the income information provided by the recipient by comparing it to information to which they have access, such as RFI (Resource File Integration), the currently stored budget, or the stored budget or actual income documentation from a current Food Stamp or HEAP case.

The legislation also calls for a periodic sample of recipients to be required to provide documentation of income and residence at renewal. This provision will be refined at a later date upon consultation with the Office of the Medicaid Inspector General (OMIG).

NOTE: Documentation of income and residence at initial application is still required for all applicants. The "Explanation of Resource Documentation Requirements", Attachment I of 04 OMM/ADM-6, on Attestation of Resources, has been revised to include attestation of income, and is included here as Attachment IV.

In addition, the Department is rescinding the policy outlined in 03 OMM/ADM-2 that allowed districts to treat a recipient's report of a change in circumstances as a renewal.

III. PROGRAM IMPLICATIONS

Sections 366-a(5)(d) and (e), and 369-ee(2)(d) of Social Services Law, enacted by Chapter 58 of the Laws of 2007, are effective January 1, 2008, and allow attestation of income and residence at renewal unless the recipient has, or seeks to have, coverage for community-based long-term care or institutional long-term care services.

Due to the resource attestation policy implemented in 2004, there is already a process in place to require differing levels of resource documentation depending upon the level of coverage an individual requests. This has been supported at application and at renewal by means of a Resource Verification Indicator (RVI code) in WMS:

a. Pregnant women and children under 19 are exempt from a resource test and receive all covered care and services (RVI=9 when all household members have no resource test);
b. A Medicaid eligible individual can attest to resources and receive Community Coverage without Long-Term Care, a limited benefit package of Medicaid covered services (RVI=3);
c. FHP recipients can attest to the amount of their resources (case type 24 does not require an RVI code).

The RVI code will also be utilized to implement attestation of income and residence. The renewal form has been redesigned to allow recipients to attest to income and residence as well as resources, based upon the case's RVI code – 9(exempt from resource verification), 3(resources not verified – attestor), or no RVI code (FHPlus cases).

Individuals who currently have, or who need, community-based or institutional long-term care will continue to be required at renewal to document income, change of residence, and resources. They are:

- An individual who is institutionalized and requires Medicaid coverage of nursing facility services; RVI=1;
- An individual who requires community-based long-term care; RVI=2;
- An individual who receives all services except nursing facility services, or outpatient coverage with no nursing facility services, and who documented the previous 36/60 months' resources, and is in a transfer penalty period; RVI=4.

The renewals these individuals will receive have not been changed as a result of this legislation. Based upon their RVI codes – 1, 2, and 4 respectively – their renewals will instruct them to document income, resources, and residence (if they have moved) if they want to continue to receive Medicaid coverage for long-term care services.

Exception: Recipients who are, or expect to be participating in the excess income program will be asked to submit proof of their income (and child/adult care and third party health insurance deductions, if any), **regardless of their RVI code**, so that their spenddown amount can be calculated as precisely as possible. This instruction will appear in renewals generated after the February, 2008 migration.

Renewal Simplification does not include the Transitional Medical Assistance (TMA) extension cases and Stenson extensions. TMA recipients are still required to document income when they return their TMA mailers. Individuals who lose SSI are given an extension in order to allow a separate determination of their continued Medicaid eligibility. As they are given an RVI code of 1, their mail renewals will request documentation.

IV. REQUIRED ACTION

A. Renewals

Effective with the October 22, 2007 WMS/CNS migration, the upstate CNS-generated renewal form has been revised to reflect attestation of income and residence. Recipients who are "exempt" or "attestors" will no longer be required to provide proof of their income and new residence, if it has changed. Individuals renewing for an authorization date after January 1, 2008 should be using the updated version of the renewal form. However, some individuals may still receive and return the former renewal form, which requests documentation of income and new residence. Districts are advised not to close or discontinue a recipient due to failure to submit documentation of income or new residence with any renewals received after January 1, 2008.

Additionally, recipients who are attestors will no longer need to document their child/adult care expenses. This change to the renewal form was migrated in the February 2008 WMS/CNS release. Documentation of health insurance premiums and new health insurance will continue to be requested. However, if a recipient is paying a health insurance premium and fails to document it, if s/he is eligible without the deduction of the premium, the case is to be processed without the deduction. If the recipient needs the deduction to remain eligible, the case should be pended and the documentation requirements form (LDSS-2642) sent, allowing 10 days for the recipient to submit proof of the amount paid.

NOTE: When the agency is reimbursing the recipient for the premium, documentation of the premium amount must be submitted before reimbursement is authorized.

Although they are no longer required to document income if they are not seeking Medicaid coverage of long-term care services, individuals who are participating in the MBI-WPD Program must still document that they are employed. The renewal form is being updated to ask for documentation of employment from anyone enrolled in the MBI program. This change was migrated in the February, 2008 migration.

As noted above, individuals who are receiving community-based long-term care services and nursing facility services are still required to document their income, current resources and new residence. The renewal form sent to these individuals will continue to ask for this documentation. However, if these individuals fail to submit documentation of income, new residence, or resources, districts must send a documentation requirements form (LDSS-2642) requesting the missing documentation. If the recipient does not return the requested documentation within ten days, districts must not discontinue coverage, but must authorize Community Coverage without Long-Term Care.

B. Income Attestation at Renewal

As noted earlier, the local district must verify the accuracy of the income information provided by the recipient in order to redetermine eligibility. This is done by using current information to which the LDSS has access, such as RFI and the Work Number. When using RFI, districts must only consider information from the most recent calendar quarter, i.e., the calendar quarter immediately preceding the current calendar quarter as current. Information from any prior calendar quarter is to be considered as "no hit on RFI". Additionally, districts should utilize information in the case record and the last stored budget to compare what was previously budgeted with what is currently reported.

Attachment I is a desk aid developed to assist districts in budgeting the correct income at renewal, and the following general principles must be followed.

1. If there is a discrepancy between what is reported on the renewal and what is on the RFI, but such discrepancy is insufficient to affect program eligibility, i.e., the recipient remains eligible for the same program/benefits, budget the amount reported on the renewal. No follow-up with the recipient is required.

2. If the amount reported by the recipient exceeds both the MA and FHPlus levels, budget the amount reported rather than what is on RFI and close the case or authorize the Family Planning Benefit Program, if eligible.

Note: If a Medicaid/Medicare recipient reports income that exceeds the MA level, districts must evaluate the recipient's eligibility for the Medicare Savings Program (MSP). If the amount of income reported also exceeds the MSP levels, please remember to close the Medicare Buy-In span on eMedNY.

3. If there is a discrepancy between reported income and RFI, and budgeting the amount on RFI would result in a **downgrade** of coverage (MA to FHPlus), change the coverage to FHPlus and send a manual notice (see Attachment II) in lieu of the CNS-generated notices for this action (reason codes U85, U86 and U89), which informs the recipient that the change in coverage is the result of a computer match, and gives him/her the opportunity to supply documentation that refutes the income on RFI. This change in coverage requires at least ten days' notification. However, the effective date of the downgrade in coverage must be timed in accordance with managed care pulldown dates for enrollment into FHPlus **to avoid a gap in coverage.** This may mean extending Medicaid coverage more than the ten day notification period. See "Note" on the following page.

A printed copy of the RFI (or other) match should be made and stored in the case record to document the reason for the downgrade.

If a Medicaid recipient **reports** income in the FHPlus income range, CNS reason code U85, U86 or U89 may be used as appropriate to advise the recipient that coverage is being moved from Medicaid to FHPlus due to income. These three notices are being revised to include language that advises that the downgrade to FHPlus may be based upon a computer match. Once they are revised, the manual notice will no longer be necessary.

NOTE: Recipients enrolled in Medicaid managed care should be moved to the same plan's FHPlus benefit package. In rare cases, it may be necessary to assist the Medicaid fee-for-service recipient or the Medicaid recipient who is enrolled in a plan that does not participate with FHPlus in selecting a FHPlus plan. With the passage of the 2008-2009 State budget, auto-assignment for FHPlus recipients who fail to pick a plan will be possible. Instructions will be provided as soon as they become available. In the meantime, **Medicaid coverage must continue until the transition to FHPlus can be made,** including the plan enrollment.

EXCEPTION: There is one exception to downgrading coverage based on information from an RFI match: if a child is on the case and using the RFI information results in ineligibility for Medicaid for the child, the LDSS must pend (defer) the case, send a documentation requirements form (LDSS-2642) and allow ten (10) days for the client to submit income documentation. If the client fails to submit the requested documentation, the case may be closed with a timely notice.

4. If there is a discrepancy between reported income and RFI, and using RFI data would result in an **upgrade** of coverage (FHPlus to MA), the LDSS must budget the amount reported by the recipient and keep the recipient in FHPlus. In this situation, the assumption is that if the recipient is reporting a higher amount of income than RFI displays, it is most likely income that is too recent to be on RFI, or income that may never appear on RFI, such as "off-the-books" income.

5. If there is a discrepancy between reported income and RFI, and budgeting the amount on RFI would result in ineligibility for both Medicaid and FHPlus, the district must request documentation of the current income using a documentation requirements form (LDSS-2642) and give ten (10) days for the client to provide the documentation. If the client fails to submit the requested documentation, the case may be closed with a timely notice.

NOTE: When using RFI as a tool to verify income at any point after initial application, only Bendex and UIB may be regarded as primary sources of verification to close a case. However, while Bendex reflects a net, rather than a gross, amount, it only reflects the Medicare premium deduction. It does not reflect whether child support or back taxes, for example, are being withheld from a recipient's Social Security check. Therefore, if there is any indication that the net figure on Bendex is incorrect, you may wish to use the State On-line Query System (SOLQ), which shows both net and gross and all deductions.

6. There are circumstances when no current RFI hit, or no RFI hit at all, will occur, for example, when an individual is self-employed or working "off-the-books", or in a child only case or when only one spouse is applying, due to the fact that individuals who are not applying are not required to supply their social security numbers, or when a "New Hire" hit occurs. In these situations, the following actions should be taken:

- If the amount reported results in the recipient remaining eligible for the same program, budget the amount reported, as in #1 above.

- If the amount reported exceeds both the MA and FHPlus levels, budget the amount reported and close the case, or move to the FPBP, if eligible, as in #2 above.

- In child only cases, if the amount reported makes the child ineligible, budget the amount reported and close the case, or move to the FPBP, if eligible, as in #2 above.

- In self-employment cases, compare the income reported to the income appearing in the previous year's MBL budget. If budgeting the amount reported would result in either a **downgrade** of coverage (MA to FHPlus) or an **upgrade** (FHPlus to MA), pend the case and request income documentation using a documentation requirements form (LDSS-2642) and give ten (10) days for the client to provide the documentation. If the client fails to submit the requested documentation, the case may be closed with a timely notice.

- As you are aware, "New Hire" information on RFI does not include income data. If there is a "New Hire" hit on RFI which matches the name of the employer that the recipient lists on the renewal, and budgeting the amount of income that the recipient reports would result in a **downgrade** of coverage, i.e., would move the recipient from Medicaid to FHPlus, change the coverage to FHPlus as in #3 above. However, if budgeting the amount of income that the recipient reports would result in an **upgrade** of coverage (FHPlus to Medicaid), send an Employment Verification form, LDSS-3707, to the employer to document the new income. If the employer fails to return the form, a documentation requirements form (LDSS-2642) must be sent to the client, allowing ten (10) days for the client to provide the documentation. If the client fails to submit the income documentation, the case may be closed with a timely notice.

The examples in Attachment III help to explain when documentation may be required.

Attestation of income may result in inaccuracies in the reporting of income, as some recipients may attest to an amount from memory, rather than consulting their pay stubs, or may record the incorrect figure from their pay stubs, etc. In order to avoid an increase in recovery actions, please contact your local district liaisons before making a recovery referral.

C. Continuity of Renewal Date

Districts were previously advised in 03 OMM/ADM-2 that they may treat an eligibility determination completed as a result of an individual or family reporting a change in circumstances as a renewal, and may extend the authorization of the individual or family for 12 months from the date of the re-determination. Effective with the release of this Directive, the Department is rescinding this policy. In an effort to establish a consistent annual renewal date that will become familiar to the client, authorization periods established upon opening should not be changed before the next annual renewal.

If a change is reported by telephone between renewals, recipients may attest to the change, but before the case can be rebudgeted, a signed, written statement must be submitted by the client.

Exception: The 60-day postpartum renewal will result in a change in the usual renewal date for the families of pregnant women.

D. New Residence at Renewal

When a community Medicaid recipient without long-term care or a Family Health Plus recipient reports a new address at renewal, documentation of the new address is not required unless there is information to the contrary. Likewise, if a renewal is returned to the agency by the U.S. Postal Service with a forwarding address label, and the client still resides in the district, the renewal should be re-mailed to the new address with no further documentation of address needed.

If a renewal is returned by the U.S. Postal Service with a forwarding address label indicating that the client now resides in a different county, the renewal should be re-mailed to the new address. If it is returned to the district, the renewal must be processed before transitioning coverage to the new district, as described in the Luberto v. Daines Local Commissioners Memorandum, currently in draft.

If a recipient reports an address change between renewals by telephone, s/he must also submit a written, signed statement confirming the new address.

E. Temporary Assistance/Food Stamp Implications

Temporary Assistance (TA) recipients who are also in receipt of Medicaid who fail to submit documentation of income and/or new residence at recertification and lose TA eligibility, must have their Medicaid extended until the end of their current authorization period, then renewed, or, if their authorization is at an end, a separate determination of Medicaid eligibility.

In counties that have combined Food Stamp/Medicaid units, the LDSS-3174, "Recertification for Temporary Assistance (TA) – Medical Assistance (MA) – Medicare Savings Program (MSP) – Food Stamp Benefits (FS)" is the only acceptable renewal form if a district wishes to use a single form for a combined Food Stamp/Medicaid renewal. The LDSS-4826, "Food Stamp Benefits Application/Recertification" does not contain all of the information required for a Medicaid renewal, nor the appropriate Rights and Responsibilities language.

Food Stamp (FS) recipients who are also in receipt of Medicaid who fail to submit documentation of income and/or new residence at recertification and lose FS eligibility, must have their Medicaid eligibility re-determined.

V. NOTICE REQUIREMENTS

The following renewal forms and cover letters have been changed to no longer ask for documentation of income or new residence for Medicaid recipients receiving community coverage without long-term care, FHPlus recipients, SLIMBs, Medicaid Cancer Treatment Program recipients, and FPBP recipients:

- Z61 – Cover letter and renewal form for Community Coverage
- Z62 – Cover letter and renewal form for SSI-Related
- Z46 – MA Recert- SSI Related Mail-In SLIMB
- Z47 – Notice of Renewal(Recertification for BCCCTP)
- Z48 – Cover Letter for FPBP Renewal Form

Numerous changes have been made to upstate CNS undercare notices to accommodate the new policies contained in this directive. CNS S63, X23, S87, S64, C27, and S65 have all been updated to reflect attestation of income and residence at renewal. T03 and T04 will be updated in the 2008.2 migration.

The WMS and CNS Code Cards will also be updated to reflect these changes and any new codes. See the October 9, 2007 WMS/CNS Coordinator letter for more information about the initial changes to the renewal.

New York City renewal changes will be provided under separate cover.

VI. SYSTEM IMPLICATIONS

There are no system changes needed due to these provisions. The current RVI codes will continue to identify those recipients who attest to their resources, document current resources, complete a full asset review, or are exempt from a resource test.

VII. EFFECTIVE DATE

The provisions of this directive apply to all renewals with authorization "From" dates on or after January 1, 2008.

Deborah Bachrach
Deputy Commissioner
Office of Health Insurance Programs