



# Department of Health

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**ADMINISTRATIVE DIRECTIVE**

**TRANSMITTAL:** 17 OHIP/ADM-02

**TO:** Commissioners of Social Services

**DIVISION:** Office of Health Insurance Programs

**DATE:** November 29, 2017

**SUBJECT:** Asset Verification System

**SUGGESTED DISTRIBUTION:**

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**ATTACHMENTS:**

See Appendix for a Listing of Attachments

**FILING REFERENCES**

Previous Ref. ADMs/INFs	Releases Cancelled	Dept. Regs. Law	Soc. Serv. & Other	Manual Ref	Misc.
89 ADM-47 96 ADM-08 06 ADM-05 02 OMM/ADM-3			SSA 1940		GIS 14 MA/16 GIS 16 MA/04

## I. **PURPOSE**

The purpose of this Office of Health Insurance Programs Administrative Directive (OHIP/ADM) is to advise local departments of social services (LDSS) of the implementation of an Asset Verification System (AVS) for purposes of determining Medicaid eligibility for SSI-related applicants/recipients (A/Rs).

## II. **BACKGROUND**

Federal law at 42 U.S.C. § 1396w requires states to implement a program for verifying assets for purposes of determining and re-determining Medicaid eligibility for aged (age 65 or over), certified blind and certified disabled A/Rs. This asset verification program must meet the following minimum requirements:

- Verification inquiries and responses must be sent and received electronically through a secure internet or similar system;
- Verification requests must be sent to financial institutions other than those identified by applicants/recipients, based on logic that includes a bank's geographic proximity to the individual's home address, or other reasonable factors; and
- The inquiries must include a request for information on both open and closed accounts, going back up to five years as determined by the State.

Although the State has a system for verifying assets held in banking institutions through the Financial Institution Recipient Match (FIRM) in the Resource File Integration Subsystem (RFI), the RFI/FIRM process does not meet the requirements specified in 42 U.S.C. § 1396w.

To comply with the federal requirements, the Department of Health (DOH) contracted for the creation of an asset verification system (AVS). This AVS allows for the electronic exchange of financial account information with national, regional and local financial institutions, and real property information with public records databases. Inquiries and responses are processed through an AVS portal.

## III. **PROGRAM IMPLICATIONS**

### A. **AUTHORIZATION TO VERIFY ASSETS THROUGH AVS**

An SSI-related A/R and his/her spouse must authorize the electronic verification of their assets as a condition of Medicaid eligibility. This requirement applies regardless of whether an applicant is attesting to the value of resources for community coverage without long-term care or seeking Medicaid coverage of community-based long-term care or nursing home care.

#### 1. **Exceptions**

- a. Incapacitated individuals, who are not capable of authorizing the electronic

verification of assets through the AVS and who do not have another person authorized to sign on their behalf, are not required to provide AVS authorization. However, if the individual is applying for Medicaid coverage of community-based long-term care or nursing home care, and a petition for guardianship has not been filed on behalf of the A/R, the A/R is required to submit paper documentation to verify his/her resources.

- b. The parents of SSI-related children are not required to provide AVS authorization, since resources owned by the parents are not always considered in determining the child's eligibility. Paper documentation of resources will continue to be required, if applicable.
- c. An SSI-related A/R (and his/her spouse) who is eligible for Medicaid Extended Coverage as a NYS Partnership for Long Term Care (NYSPLTC) policyholder with Total Asset Protection is not required to provide AVS authorization.
- d. Institutionalized individuals in the Modified Adjusted Gross Income (MAGI) category of assistance may, but are not required to, provide AVS authorization for purposes of reviewing resources for the 60-month look-back period for coverage of nursing home care. If authorization is not provided, paper documentation of resources for the look-back period will be required.

## **2. Manner of Authorization**

The A/R's signature on the Medicaid application and renewal form is sufficient authorization to verify assets through AVS. Supplement A (DOH-4495A) to the Access NY Health Care Application (DOH-4220) and several renewal forms have been revised to obtain a non-applying spouse's authorization to verify assets through AVS. In addition, new forms were created for use in situations where the A/R and/or the A/R's spouse do not sign the Medicaid application or the renewal form.

## **B. INFORMATION AVAILABLE THROUGH AVS**

Generally, the AVS will electronically verify accounts held in banking institutions, and conduct searches on real property, owned by the A/R and/or the A/R's spouse during the month of application and the three-month retroactive period.

For individuals applying for Medicaid coverage of nursing home care, the AVS will:

- Verify the A/R's and the spouse's accounts held in banking institutions for the month of application and the 60-month look-back period, including accounts that were closed during this period, and identify months in which a potential transfer of assets is detected; and
- Conduct searches on real property owned by the A/R or the A/R's spouse during the month of application and the 60-month look-back period, including any property that was sold or transferred during this period.

### **C. WHEN PAPER DOCUMENTATION IS NECESSARY**

Paper documentation **will** be required:

- If the AVS does not return a response for a bank account that was reported on Supplement A, and the individual is applying for community-based long-term care or nursing home care;
- To further review transactions in months in which the AVS identifies a potential transfer of assets;
- For assets that cannot be verified through the AVS, if the individual is applying for Medicaid coverage of long-term care services or renewing coverage of nursing home care; the AVS only reports on financial accounts held in banking institutions, and cannot be used to verify stocks, bonds, securities, and mutual funds purchased through a brokerage firm, or life insurance policies and annuity products issued by insurance companies; and
- In certain circumstances, if there is a discrepancy between information provided by the A/R and the results of the AVS inquiry; for a more detailed discussion, see section IV.D of this directive.

Districts will continue to receive information on computer matches with financial institutions on the RFI report. Since the bank account information provided through the AVS is current, the account balance information provided in the AVS portal is to be used in the eligibility determination. If a financial institution account is reported on RFI, but is not reported by the A/R or included in the AVS result, the specific bank may be queried through the AVS. If the information cannot be obtained through the AVS, follow-up with the A/R is required.

## **IV. REQUIRED ACTION**

### **A. AUTHORIZATION TO OBTAIN FINANCIAL RECORD INFORMATION**

#### **1. Applicants/Recipients**

SSI-related adults who apply for Medicaid coverage on or after the effective date for implementation of the AVS in their district, are required to authorize the electronic verification of assets as a condition of eligibility for Medicaid. The authorization language is included within the existing “Terms, Rights and Responsibilities” section of the Access NY Health Care Application (DOH-4220) and in the “Notices, Assignments, Authorizations, and Consents” section of the Common Application (LDSS-2921). Therefore, the required authorization is obtained when the Medicaid application is signed by the applicant, the applicant’s spouse on behalf of the applicant, or an authorized representative. The authorization remains valid until the district receives a written revocation or Medicaid coverage is terminated.

For Medicaid applications that are signed by someone other than the applicant, the applicant's spouse, or an authorized representative, a separate authorization must be obtained to allow the individual to sign the application on behalf of the applicant. The DOH-5147, "Submission of Application on Behalf of Applicant" (Attachment I) has been created for this purpose. Effective with the release of this directive, the DOH-5147 is to be made available with the DOH-4220 application form and it, or a DOH approved equivalent, is required to be completed when someone other than an applicant, the applicant's spouse, or an authorized representative signs the application. If a representative has the authority to sign the application on behalf of the applicant but does not submit documentation to support such authority with the application, the DOH-5147 can be used to ascertain the type of authority the representative has and to request supporting documentation.

- a. **Applicants Unable to Authorize** – If an applicant is unable to sign the application and is unable to authorize another individual to sign the application on his or her behalf, the individual who signs the application is required to attest to the applicant's inability to sign the application. The DOH-5147 is to be used to obtain this attestation. This attestation by the individual who is signing the application is acceptable for purposes of allowing such person to sign the Medicaid application. However, since there is no authority to authorize the electronic verification of assets through the AVS, paper documentation of resources is required for individuals applying for Medicaid coverage of long-term care services. Local districts are reminded that if an A/R is alleged to be incompetent or incapacitated and there is no one with the legal authority to act on his/her behalf, the A/R's resources are considered unavailable from the time a petition to appoint a guardian is filed until the court appoints a guardian. Once proof is submitted that a guardian has been appointed, the guardian will be required to sign the authorization to allow electronic verification of assets in financial institutions. This authorization is obtained when the guardian signs the revised Supplement A, the DOH-5148, "Authorization for Verification of Resources (Applicant)" (Attachment II) or a DOH approved local equivalent.
- b. **Application for Deceased Individual** – A Medicaid application that is filed on behalf of a deceased individual must be signed by the decedent's surviving spouse or by the legally appointed representative of the decedent's estate. If the district receives an application for an individual who is deceased and the application is not signed by the decedent's spouse or estate representative, the application must be accepted and the individual who signed the application must be notified that the application cannot be processed without the signature of the legally appointed estate representative. If the Medicaid application is signed by the decedent's spouse or estate representative, the decedent's assets can be verified through the AVS.
- c. **Referrals from New York State of Health** – For recipients who are referred to the district from New York State of Health (NYSOH) because they are no longer eligible under the MAGI category of assistance (or need care and services that can only be provided through the local district), and who are SSI-related, the authorization to verify assets through the AVS will be obtained when the renewal application is signed by the recipient, the recipient's spouse, or someone authorized to act on the recipient's behalf. A Certification and Authorization

section to obtain the AVS authorization is being added to the following renewal forms: “Renewal Letter, Individual Transferred from NYSOH (Reason Code H2W) and Authorize Medicaid Coverage, Immediate Referral from NYSOH (Reason Code H3W).” For recipients in need of nursing home care, authorization to verify assets through the AVS will be obtained when Supplement A is completed and signed by the A/R, the A/R’s spouse, or someone authorized to act on the recipient’s behalf. If the renewal/application is signed by someone other than the recipient, the recipient’s spouse or the known authorized representative, separate authorization for the individual to apply/renew on behalf of the recipient is required and may be obtained on the DOH-5147.

Pursuant to General Information System message 16 MA/04, “Referrals from NY State of Health to Local Departments of Social Services for Individuals who Turn Age 65 and Instructions for Referrals for Essential Plan Consumers,” individuals who are transferred to the Welfare Management System (WMS) from NYSOH due to turning age 65, are authorized with Individual Categorical Code 10 (Aged) when the case is opened on WMS. Although individuals age 65 and over are categorically SSI-related, asset verification through the AVS has not been authorized until the renewal form has been signed by the recipient, the recipient’s spouse or someone authorized to act on the recipient’s behalf. Since these individuals meet the criteria to be included in the renewal batch file that is sent to the AVS, an AVS Trust Indicator Code must be entered when coverage is authorized on WMS. The AVS Trust Indicator code will exclude the individual from the renewal batch file. Refer to section V.C of this directive for information on the use of the Trust Indicator field in WMS for SSI-related individuals who are not appropriate for electronic verification of assets through the AVS.

- d. **Authorization Not Received** – If the district does not receive the appropriate signature on the application, renewal form, or on a completed DOH-5147, when required, the Medicaid application must be denied. New Client Notice System (CNS) Reason Code D83, “Deny Medicaid, Failure to Submit Valid Application,” has been created to deny an application when there is no proof of authorization to allow another individual to sign the application on behalf of the applicant, or a signed attestation that the applicant is unable to authorize another individual to sign the application on his/her behalf due to incompetence or incapacity. For cases where a DOH-5147 is not submitted in relation to a H2W or H3W application/renewal, Medicaid coverage should be discontinued using Reason Code D80, “Discontinue Medicaid, Failure to Submit Valid Application.”

## 2. **Legally Responsible Spouse**

A legally responsible spouse is also required to provide authorization for Medicaid to electronically verify his/her assets as a condition of eligibility for an SSI-related A/R. This authorization must be signed by the legally responsible spouse or someone authorized to act on the spouse’s behalf. Districts must obtain this authorization in order to verify the legally responsible spouse’s assets through the AVS.

Since the Access NY Supplement A (DOH-4495A) does not include the required authorization to electronically verify assets of a non-applying spouse, a new supplement, "Supplement A (Supplement to Access NY Health Care Application)" (DOH-5178A), has been created. Effective with implementation of the AVS, districts are to begin using the new Supplement A (DOH-5178A). If a legally responsible spouse signs the DOH-5178A on behalf of the applicant, thereby authorizing asset verification for the applicant, he/she must separately authorize verification of his/her own assets by also signing the space provided for the signature/authorization of the applicant's spouse. Medicaid eligibility can be denied if authorization for each spouse is not provided. Refer to section IV.A.2.b of this directive for further information about situations where a non-applying spouse is refusing to make his/her resources available.

If a district receives a completed DOH-4495A, or a completed DOH-5178A that is not signed by the non-applying spouse, the DOH-5149, "Authorization for Verification of Resources (Legal Spouse)," (Attachment III) may be used to obtain authorization from the spouse.

Authorization to verify assets through the AVS for a Medicaid recipient's non-applying legally responsible spouse is obtained when such spouse, or someone who is authorized to act on his/her behalf, signs one of the following application/renewal forms: Renewal Letter, Individual Transferred from NYSOH (H2W); Authorize Medicaid Coverage, Immediate Referral from NYSOH (H3W); and the upstate SSI-related renewal form. Supplement A (DOH-5178A) will also be used to obtain the non-applying spouse's authorization when there is a request for an increase in coverage for the recipient and the non-applying spouse has not authorized verification of assets on a previously completed application or renewal. These applications/renewals have been revised to include a new section entitled "Certification and Authorization" where authorization language has been added for a non-applying spouse. Once a non-applying spouse's authorization has been obtained, it remains valid until it is revoked or coverage has terminated. Therefore, a non-applying spouse is not required to sign the authorization for AVS at subsequent renewals or when a subsequent request is made for an increase in coverage.

If the legally responsible spouse is also applying for Medicaid or renewing coverage and is SSI-related, his/her signature on the DOH-4220 application and/or his/her signature on the renewal form is sufficient authorization to verify assets through the AVS. For a legally responsible spouse who is eligible under a MAGI category of assistance through NYSOH, Supplement A (DOH-5178A) or the DOH-5149 form must be signed to authorize verification of assets for purposes of determining eligibility for his/her SSI-related spouse.

- a. **Non-applying Spouse's Demographic Information** – In addition to adding the AVS authorization to the above referenced applications/renewals, a section was added to obtain the non-applying spouse's Social Security number, date of birth, maiden name or other name known by, and residence. This information is needed to verify the spouse's assets through the AVS. However, since it is not a condition of eligibility that this information be provided by a non-applying spouse, Medicaid eligibility for the A/R cannot be denied or discontinued due to

the spouse's failure to provide this information. Since assets cannot be verified through the AVS if this information is missing, the spouse is required to provide documentation of his/her resources if the A/R is applying for community coverage with community-based long-term care or for coverage of nursing home care.

**Note:** The "Social Security Number" section under "Terms, Rights and Responsibilities" in the Access NY Health Care Application (DOH-4220) has been revised to request that a non-applying spouse's Social Security number be provided in order to verify records from financial institutions.

- b. **Spouse Refuses to Authorize AVS Verification of Spouse's Assets** – In cases where there is a written statement indicating that the non-applying spouse is refusing to make his/her assets available for the cost of the A/R's medical care (i.e., it is a "spousal refusal" situation), the A/R will not be denied if the non-applying spouse fails or refuses to authorize verification of his/her assets through AVS. Policy guidance for determining eligibility when an A/R's spouse refuses to make assets available is described in 89 ADM-47, "Treatment of Income and Resources for Institutionalized Spouses/Individuals and Legally Responsible Relatives."

For cases involving a spouse living apart from an SSI-related A/R, it is not a condition of the A/R's eligibility for the non-applying spouse to authorize asset verification of his or her assets. However, the non-applying spouse may be asked to voluntarily provide such an authorization, for purposes of determining the amount to be requested as a contribution to the cost of the A/R's medical care.

## **B. AVS REQUEST**

### **1. Requests Submitted Through WMS Batch File**

The request for verification of records from financial institutions and real property information will be made electronically through WMS or by submitting a request directly using the Ad Hoc function in the AVS portal. Once the request is transmitted, responses from financial institutions and results from the real property search are returned to the AVS portal for use in determining resource eligibility. The information provided in the AVS response is based on the resource documentation requirements for the type of Medicaid coverage the A/R is requesting.

The chart below identifies the codes that are used to specify the appropriate look-back period and the resource limits (effective January 1, 2017) that apply in determining resource eligibility. The "Request Type" (RT) code indicates the program or level of Medicaid coverage requested and the applicable look-back period. For community coverage (with or without long-term care services), resource information for the current month (month of application) plus the three months prior to the month of application will be returned. For institutionalized individuals seeking coverage of nursing home care, information for the current month (month of application) plus the 60 months prior to the month of application will be provided. For renewals, financial institutions will provide account information for the month the request is submitted to the AVS. The "Household Size" (HS) code specifies whether



the resources are compared to the resource level for a single individual or for a household size of two.

Upstate:

<b>Program Description</b>	<b>Request Type (RT)</b>	<b>Household Size (HS)</b>	<b>Monthly Balance Requested</b>	<b>Resource Limit (2017)</b>
Nursing Home	N	1 or 2	Current + 60 months	\$14,850
Community	C	1	Current + 3 months	\$14,850
Community	C	2	Current + 3 months	\$21,750
Community MLTC or Waiver Spousal	S	2	Current + 3 months	\$14,850
MBI-WPD	M	1	Current + 3 months	\$20,000
MBI-WPD	M	2	Current + 3 months	\$30,000
COBRA	O	1	Current	\$4,000
COBRA	O	2	Current	\$6,000

New York City:

<b>Program Description</b>	<b>Request Type (RT)</b>	<b>Household Size (HS)</b>	<b>Monthly Balance Requested</b>	<b>Resource Limit (2017)</b>
Nursing Home	EN	1 or 2	Current + 60 months	\$14,850
Community	EC	1	Current + 3 months	\$14,850
Community	EC	2	Current + 3 months	\$21,750
Community MLTC or Waiver Spousal	ES	2	Current + 3 months	\$14,850
MBI-WPD	EM	1	Current + 3 months	\$20,000
MBI-WPD	EM	2	Current + 3 months	\$30,000
NH Conversion	EV	1	Current + 60 Months	\$14,850
NH Conversion Spousal	EX	2	Current + 60 Months	\$14,850
MLTC NH	E5	1	Current + 60 Months	\$14,850
MLTC NH	E5	2	Current + 60 Months	\$14,850

**Note:** For NYC Codes RN, RC, RS and RM (renewal codes), financial account information for the current month is provided. For cases appearing on the WMS renewal batch file, the current month is the month in which the batch file is sent to the AVS.

- a. **Application Registration (Upstate)** – AVS requests for new applicants are submitted through the Application Registration screen in WMS. Two new fields have been added to accept the Request Type code and Household Size. These new fields are discussed in further detail in the “Systems Implications” section of this directive. Once it is verified that authorization to verify assets through the AVS has been received, the appropriate codes are entered in the two new fields on the WMS Application Registration Screen (WAPREG). WMS uses these codes to identify applicants who are appropriate to include in the daily batch file that is electronically sent to the AVS. In addition to entering the two AVS codes, districts must be sure to include the accurate application date, the applicant’s first and last name, Social Security number, date of birth, residence street address, residence city/town, and residence zip code when processing the AVS request. WMS will display an “Examine blinking field” message when the AVS codes are entered and any one of these fields is blank. Since the AVS search criteria is based on the residence address that is provided in the request, applications for coverage of nursing home care must be registered with the applicant’s actual residence address, not the address for the nursing home. The address information can be changed to the facility’s address, if appropriate, when eligibility is determined and Medicaid coverage is authorized in WMS. Also, if an A/R provides information on other names that he/she has been known by, this information must also be entered in WAPREG. When all of the required information has been data entered, an AVS request will be transmitted to the portal on a daily batch file. If the required fields are not completed on the WAPREG, the case will appear in error status in the AVS portal.

Additionally, since fields in WAPREG for first and last names are limited to 10 and 17 characters respectively, a name exceeding one of these limits will not be correctly displayed on the batch file and may impact whether a financial institution is able to respond. To avoid a potential error and delay in response from a financial institution, requests for applicants with lengthy first and/or last names should be submitted Ad Hoc through the AVS portal.

The new AVS codes (RT and HS) are not to be entered in WAPREG if authorization to verify resources through AVS is not present when the application is registered. These codes can be entered through an application register maintenance (ARM) transaction once the appropriate authorization is received.

Since a non-applying spouse’s information is not entered in WMS application registry, a request for a non-applying spouse must be submitted Ad Hoc through the AVS portal. Although the spouse’s information is submitted separately, the non-applying spouse is linked to the applicant in the AVS portal when the WMS Registry Number and applicant’s Social Security number is included in the Ad Hoc request. If a Medicaid Case Number is included in WAPREG, the Case Number, rather than the Registry Number should be used in the request

submitted Ad Hoc. Including the Medicaid Case Number in WAPREG and in the Ad Hoc request will ensure the portal is able to automatically submit a request for the non-applying spouse when the Medicaid recipient's information is sent to AVS at renewal. If the Medicaid Case Number is not known at the time of Application Registry, the portal's Case Correction tool can be used to update the Registry Number to the Medicaid Case Number in the AVS portal. See the "New York State Department of Health Asset Verification System User Guide" for instructions on use of the Case Correction tool.

- b. **New York City** - New AVS requests and corrections to any requests will be submitted through the Eligibility Data and Image Transfer System (EDITS), regardless of character length.
- c. **Renewals** - Batch file requests will also be submitted through WMS for most SSI-related A/Rs renewing Medicaid coverage. Individuals who are appropriate for asset verification through the AVS will be systemically identified on the monthly renewal file (WINR 4133) and included in the batch file that is automatically sent to the AVS. The renewal batch file will include only those recipients who are categorically SSI-related and have authorized AVS. Since WMS generates the monthly renewal batch file, no action is required by a district to send a renewal file to the AVS. Additionally, no action is required to submit a request for a non-applying spouse at renewal, if the Medicaid Case Number was previously used to link the couple in the AVS portal.

The AVS will not be used to verify assets for SSI-related children or their parents and cases approved for auto renewal. The WMS batch file process includes edits to exclude these individuals from the monthly renewal batch file that is sent for asset verification.

Since the renewal batch file process identifies recipients for electronic verification of assets based on categorical and age criteria, new AVS Trust Indicator codes have been developed to exclude from AVS individuals who are unable to authorize the electronic verification of assets through AVS when there is no person with legal authority to provide authorization on the individual's behalf. Additionally, since resources are not verified at renewal for qualified NYSPLTC policyholders who have met the minimum durational requirements under a Total Asset Protection plan, the appropriate indicator code must be used so these individuals are not included in the renewal batch file that is sent to the AVS. The new codes will be entered in the Trust Indicator field in WMS and must be entered when the case is processed and coverage is authorized. These codes are described in further detail in the "Systems Implications" section of this directive.

Renewal batch file edits will not identify whether a name has been shortened due to the limited number of character fields provided for first and last names. Since some financial institutions may not recognize shortened names, the portal may display an error message indicating that the bank will not respond. In these instances, if an error message is received, districts must submit a correction directly in the AVS portal. The "New York State Department of Health Asset Verification System User Guide" (AVS User Guide) includes instructions for

making corrections.

Additionally, when the WMS renewal file includes spouses that are on the same Medicaid case but are eligible under different Medicaid budgets (e.g. a community Medicaid budget and a Medicaid Buy-In for Working People with Disabilities budget, or a community Medicaid budget and a nursing home budget), the AVS cannot determine the appropriate resource level to apply in the resource calculation. In these instances, such cases will fail to populate into the portal, and districts must submit a request directly through the Ad Hoc function in the AVS portal.

## **2. Requests Submitted Ad Hoc Through the AVS Portal**

Requests that cannot be transmitted electronically through a WMS batch file will be submitted Ad Hoc directly through the AVS portal. This will include AVS requests:

- For recipients who are seeking an increase in coverage for long-term care services in the community or for nursing home care;
- For recipients whose category of assistance changes to SSI-related;
- To verify assets of a non-applying spouse;
- For applicants that have a first name longer than 10 characters and/or a last name with more than 17 characters; and
- That were included in a renewal batch file, but failed to be transmitted due to an error (e.g. a required field was missing).

**Note:** If an “institutionalized spouse” is receiving services in the community (managed long-term care or waiver services) and subsequently requires nursing home care, the community spouse’s resources are required to be reviewed for the 60-month look-back period under the transfer of assets provisions. In this situation, an Ad Hoc request would be made for both the institutionalized spouse and the community spouse, allowing the AVS to gather resource information for the applicable look-back period.

NYC will be using the EDITS system to submit AVS requests and any needed corrections, including those for non-applying spouses. With a few exceptions, NYC will not be completing Ad Hoc requests directly in the AVS portal. Instructions for submitting such AVS requests for NYC will be provided in separate training documents.

Districts are reminded that once eligibility is established for an institutionalized spouse under spousal impoverishment rules, resources of the community spouse are not considered to be available for the cost of care. Therefore, at renewal, an Ad Hoc request would not be made for a non-applying community spouse. Although the spouse’s information was requested to determine eligibility for coverage of nursing home care and is part of the institutionalized spouse’s case in the AVS portal, the AVS will not automatically send a request for information on a community

spouse when the institutionalized spouse is received on the renewal batch file, unlike community cases.

**Referrals from NY State of Health** - Cases that are being transferred from NY State of Health are authorized coverage on WMS for the month of referral and three additional months (four additional months in NYC). An individual whose category of assistance is not SSI-related at the time of transfer, will not be included in the renewal batch file that is sent to the AVS. The renewal form that is sent to these individuals will include the AVS authorization. When re-determining eligibility for individuals whose category of assistance is changing to the SSI-related category, an AVS request must be sent via Ad Hoc once authorization is received. Individuals transferred from NYSOH to WMS due to turning age 65 are considered categorically SSI-related and are authorized Individual Category Code 10. Although asset verification through the AVS has not been authorized, these individuals meet the criteria to be included in the renewal batch file that is sent to AVS, unless the appropriate AVS Trust Indicator Code is entered in the Trust Indicator field in WMS. Refer to section V.C of this directive for information on the use of the Trust Indicator field for individuals who have not authorized verification of assets through the AVS.

### **3. Specific Bank Query**

In addition to submitting verification requests to banks selected by the AVS, districts should query the specific banks that are listed on the Supplement A/renewal by utilizing the “Add Additional Banks for Verification” tool in the AVS portal. The tool can be accessed once a case is established in the portal (the next day, for requests submitted via batch file through WMS, or the same day for requests submitted Ad Hoc through the AVS portal).

The “Add Additional Banks for Verification” tool is to be used in place of any manual bank/resource clearance process that districts had in place prior to implementation of the AVS.

## **C. AVS PORTAL RESPONSES**

Requests that are successfully transmitted to the AVS portal via batch file or Ad Hoc create a case in the AVS portal. The portal forwards the information necessary to process an AVS request to the agencies contracted to report on accounts held in banking institutions and for real property searches. All information received from records with financial institutions and from the real property search is maintained in the A/R's case within the AVS portal. The case will also include information received on assets owned by a non-applying spouse. When both spouses are applying for or renewing coverage, information on each spouse may be combined into one case in the portal based on how the information was provided in the AVS request. The AVS User Guide provides instructions for combining or separating case information in the portal.

The portal may begin receiving responses from banking institutions and real property searches the day after the request is submitted to the AVS. Districts are instructed to wait 10 calendar days (not business days) from the date the request was submitted to the AVS before reviewing the resource information in the portal. Throughout the 10-day period, the portal will review the bank account information received and apply the

appropriate resource level. The resource calculation will update when new bank account information is received, until the case is processed and the eligibility decision is indicated in the AVS portal. Once 10 days have elapsed, the portal displays the outcome of the resource calculation and alerts the user that the results are ready for review. The portal will continue to populate any responses from financial institutions for 90 days from the date the request was submitted to the AVS. Refer to section IV.D.2 of this directive for further information on late AVS responses. The AVS User Guide describes the portal's display of bank responses received after an eligibility decision has been made.

The resource calculation performed by the AVS portal excludes certain financial institution accounts that may not be a countable resource under Medicaid resource counting rules. These include retirement funds (including annuities), burial accounts and life insurance policies. Since real property may not be considered a countable resource, the value of any real property found is also excluded from the portal's resource calculation.

For request types that require asset information for the 60-month look-back period, the portal will perform a review of the bank account information received and based on business rules established by the Department, will provide an alert (transfer flag) when a potential transfer of assets is detected. A transfer flag may appear for one month or several different months on a specific bank account or on different accounts. In determining Medicaid eligibility for coverage of nursing home care, districts are required to request further information from the A/R to document the reason for a change in resources for the month(s) identified by the AVS transfer flag. Since the portal displays a transfer flag for a month(s) in which an increase or decrease from the prior month is detected, requested documentation would include the bank statement for the month prior to the month in which the transfer flag appears. This will provide appropriate information to confirm whether a potential transfer of assets has occurred. This is required if the A/R is otherwise resource eligible.

The portal maintains a history of the asset information provided through the AVS. Since the information is maintained in the portal, districts are not required to copy and scan the AVS result into I/EDR, or maintain a copy in the case record. Although the information is used in the eligibility determination, the portal is not considered to be part of the case record. However, if an eligibility decision is based on responses received through AVS, a notation must be made in the case record that AVS was used in the determination. Districts have the capability to print a copy of the information and are required to print relevant sections if needed to support an eligibility decision at a fair hearing. If information provided in the AVS portal is printed for purposes of supervisory review or to support an eligibility decision for a fair hearing, the printed sections are considered part of the case record and must be scanned into I/EDR or equivalent case record storage.

## **D. ELIGIBILITY**

### **1. Reported Resource Information from the AVS**

The AVS verifies ownership interest and value of real property and the value of assets held in banking institutions for purposes of (re)determining resource eligibility for SSI-related adult A/Rs. Information provided through the AVS may include bank

accounts and/or real property that was not reported by the A/R. Districts are required to identify undisclosed accounts that are received by selecting the “Unreported” button for the appropriate bank listed in the Account Information section of the portal. AVS may also provide information that does not agree with the resource value reported by the A/R on the application/renewal or it may not provide a response for a specific bank listed on Supplement A. The following rules apply to the comparison of information reported on the application/renewal and information reported through the AVS.

**Note:** These rules also apply to SSI-related A/Rs who apply for or are in receipt of Medicaid coverage without long-term care.

- a. If a financial institution account and its value are reported on Supplement A, but the bank account is not verified through the AVS within 10 days after the request is submitted, paper documentation is required for individuals applying for community coverage with community-based long-term care or nursing home care. If documentation is not provided and the bank does not respond through the AVS, Medicaid coverage of long-term care services is denied. For A/Rs applying for or renewing community coverage with no long-term care and recipients renewing community coverage with community-based long-term care, the district is to include the attested amount of the resource in the determination of eligibility. Similarly, if real property that is listed on Supplement A is not reported through the AVS, documentation is required if the applicant is seeking Medicaid coverage for long-term care services. For community coverage with no long-term care and for recipients renewing community coverage with community-based long-term care, the attested amount of the real property is to be used in determining eligibility, as appropriate.
- b. When an AVS response is received for all bank accounts and real property listed on Supplement A/renewal and the total value based on information reported on Supplement A/renewal and through the AVS, combined with other countable resources the A/R may have, is at or below the Medicaid resource level, no further bank account or real property information is required. The amount attested to on the Supplement A/renewal is entered in the WMS budget.

If there is an undisclosed resource reported through the AVS, but the total countable resource amount including the undisclosed resource, is at or below the Medicaid resource level, no further documentation is required and eligibility is determined using the information from the AVS.

- c. If the total countable value of the resources listed on Supplement A/renewal is above the Medicaid resource level and there is an AVS response for each bank account and real property listed but the AVS values returned are lower than the attested amounts and together with other countable resources, the total countable resource value is at or below the Medicaid resource level, the district should determine eligibility using the resource amounts attested to on the Supplement A/renewal and deny/discontinue.

- d. In situations where the bank accounts listed on Supplement A/renewal are matched through the AVS, but the amount returned through AVS, when added to other countable resources, is different than the amount listed on the Supplement A/renewal, and both totals are over the Medicaid resource level, districts must use the higher of the two values to (re)determine eligibility. This includes situations where the AVS reports an undisclosed bank account.
- e. When all bank accounts listed on Supplement A/renewal are matched through the AVS and the total value combined with other countable resources is at or below the Medicaid resource level but the combined AVS values together with other countable resources is above the Medicaid resource level, the district must determine eligibility using the AVS values. However, if paper documentation is submitted with the application, or after, the paper documentation must be reviewed prior to denying/discontinuing coverage.
- f. Notices informing A/Rs of a determination of excess resources have been revised to inform the individual that information from a computer match with financial institutions was used to determine eligibility, and to advise the A/R of the timeframe for disputing the excess resource amount stated in the eligibility decision notice. The revised notices advise the A/R to contact the district within 30 days from the date of the notice to dispute the excess resource amount. This could also include the situation where the AVS reports an undisclosed bank account. If information to resolve the discrepancy is provided within the required time period, eligibility must be re-determined and coverage authorized, if appropriate. If the information provided continues to support the denial/discontinuance or liability toward cost of care, no further action is required.
- g. If the AVS portal returns real property results which would make an A/R ineligible due to excess resources, the district must contact the A/R to confirm the ownership and value of the property prior to denying/discontinuing coverage.
- h. For A/Rs seeking Medicaid coverage of community-based long-term care or nursing facility services, the eligibility determination includes a comparison of any equity value in a homestead to the home equity limit (see 06 ADM-05 for further information regarding the home equity limit). If the fair market value reported through the AVS exceeds the home equity limit and the AVS data does not include an outstanding mortgage value, districts must request documentation to determine the value of the equity interest. If the fair market value reported through AVS does not exceed the home equity limit, no further documentation is required.

## **2. Other Resource Documentation Requirements**

A/Rs requesting community coverage with community-based long-term care will continue to be required to document resources that cannot be verified through the AVS (e.g. stocks, bonds, mutual funds, etc.). These individuals must continue to be authorized with a Resource Verification Indicator (RVI) code of 2 (resource documentation provided for current resources). Individuals requesting community



coverage without long-term care are not required to document resources. These individuals must continue to be authorized with a RVI code of 3 (attested to value of resources), regardless of resource information provided through the AVS.

For financial institutions that do not have a relationship with PCG's subcontractor, account information cannot be obtained through the AVS. The A/R remains the primary source of providing verification. When an A/R is unable to provide documentation, and establishes that reasonable efforts were made to obtain the required information, the district must conduct a collateral investigation.

Districts must be mindful of the requirement to determine eligibility within 45 days of the date of application when requesting documentation of resources that are not provided through the AVS. Resource documentation is required for accounts that may not be maintained in a banking institution (e.g. retirement and burial accounts, stocks, bonds, mutual funds, etc.). The Supplement A must be reviewed as soon as practicable once received by the district to ensure timely submission of the AVS request and to determine whether documentation of other resources is required. This includes documentation of any current or closed bank accounts, and any currently owned or previously owned real property that is not reported in the AVS response.

If there are resources other than those included in the AVS result, the resource information in the portal is added to these other resources to determine resource eligibility for the appropriate month. The amount displayed in the AVS Summary section of the portal is based on the balance of countable financial institution accounts only. The value of any real property owned by the individual is not included since the treatment of real property as a countable resource varies under Medicaid eligibility rules. Districts must apply current policy in determining the treatment of real property. If any real property is determined to be a countable resource, the value must also be added to the AVS balance of the financial institution accounts.

Although documentation of bank account information provided through the AVS cannot be required, other than to resolve discrepancies, districts have the option of reviewing any account statements that may be provided by the A/R or the A/R's representative. If the statements are reviewed and there is indication of a potential transfer, the district must request further information concerning the potential transfer of asset. This review is required regardless of whether the information in the AVS portal alerts the district of a possible transfer of assets. If an A/R attests on the Supplement A to resources under the Medicaid resource limit, and the AVS results indicate resources over the Medicaid resource limit, and bank statements were submitted with the application, then the submitted documentation must be reviewed prior to denying/discontinuing coverage.

**Late AVS Responses** - While most banks should respond within 10 days of the request, financial institutions may return results to the portal up to 90 days after the request was submitted. For some cases, Medicaid eligibility may have been authorized, or denied before a bank response is received through the AVS. Late AVS responses are responses that are received after an eligibility decision has been made. Districts are required to review and may have to act on account

information that is provided after an eligibility decision on the case has been made.

When a late AVS response is received for an individual who was authorized Medicaid based on the value of resources he/she attested to on the Supplement A/renewal, and the account information provided in the late response would make the recipient ineligible due to excess resources, coverage is discontinued with timely notice and the individual has 30 days to provide information concerning the discrepancy. This rule applies regardless of whether the late response is received from a bank that was reported on Supplement A/renewal or for an account that was not disclosed by the A/R. If information to resolve the discrepancy is provided within the 30-day period, eligibility should be re-determined and coverage authorized, if appropriate. If the information provided continues to support the discontinuance of coverage, no further action is required.

Since individuals who applied for and were determined eligible for community coverage with community-based long-term care would have provided statements for banks that did not respond within 10 days of the AVS request, no action is required if a late response is received for a bank account that was previously documented. If the late response is from a bank that was not disclosed by the A/R, eligibility must be re-determined. A new eligibility notice is not required if the individual remains resource eligible. If the undisclosed account information results in a recipient being determined ineligible due to excess resources, coverage must be discontinued with timely notice and the individual has 30 days to provide information concerning the undisclosed account.

If Medicaid coverage was denied, regardless of the reason, and a late AVS response is received, no action is required unless the applicant submits new information.

For individuals who applied for and were determined eligible for coverage of nursing home care, no action is required if a late response is received for an account that was previously documented. If the late response is for a bank account that the individual did not report on the Supplement A/renewal, eligibility must be re-determined, and if applicable, a transfer penalty must be imposed. Districts are required to request documentation for month(s) where a transfer flag identifies a potential transfer of assets, if the individual is otherwise eligible.

If a re-determination of eligibility results in incorrectly paid Medicaid, districts are to follow the policy and procedures described in Administrative Directive, 02 OMM/ADM-3, "Medicaid Liens and Recoveries."

Account information for late AVS responses received will appear in a separate case queue in the Account Information section in the AVS portal. Districts are required to identify undisclosed accounts that are received in a late response by selecting the "Unreported" button for the appropriate bank listed in the Account Information section of the portal.

## E. NEW FORMS/NOTICES

The following forms and notices are to be used by local districts effective with implementation of the AVS:

### 1. **DOH-5147 - Submission of Application on Behalf of Applicant**

The DOH-5147 (Attachment I) is to be used if someone other than the applicant, applicant's spouse or authorized representative signed the Medicaid application. This form is also to be used if the applicant is incompetent or incapacitated and unable to sign the application.

### 2. **DOH-5148 - Authorization for Verification of Resources (Applicant)**

This form (Attachment II) may be used to obtain the SSI-related applicant's authorization to verify his/her resources with financial institutions, when they have not signed the Supplement A (DOH-5178A).

This form must be sent with a document request letter when needed. (See the "Authorization" section for examples of when this form would need to be signed.)

### 3. **DOH-5149 - Authorization for Verification of Resources (Legal Spouse)**

The DOH-5149 (Attachment III) is to be used to obtain the authorization of a spouse who has not previously authorized AVS.

This form must be sent with a document request letter when the non-applying/legal spouse fails to sign the renewal or Supplement A (DOH-5178A). This form also contains a section for the spouse to provide his/her Social Security number, date of birth, maiden name or other name known by, and residence. If the non-applying spouse authorized AVS on the application or on a prior renewal form, reauthorization is not required.

### 4. **OHIP-0094 (Rev 05/15) - Notice of Action on Your Medicaid Application/ Benefits (Withdraw/Failure to Provide Authorization for Asset Verification)**

This notice (Attachment IV) must be used to inform the A/R of a denial or discontinuance of Medicaid benefits due to failure to provide a signed authorization to verify resources with financial institutions for the A/R and/or spouse. This notice must be sent if the A/R was sent a document request letter to sign the authorization on a DOH-5148 (Attachment II) or DOH-5149 (Attachment III) and failed to provide the signed authorization.

This notice must also be used to inform the A/R of a denial or discontinuance of Medicaid benefits if a request to revoke the authorization to verify resources with financial institutions for the A/R and/or the A/R's spouse is received.

## F. REVISED MANUAL NOTICES

The following notices have been revised to inform an SSI-related A/R that information from a computer match with financial institutions was used in the eligibility determination, and to contact the agency immediately, but no later than 30 days from the date of the notice to dispute the excess resource determination:

- OHIP-0098 (formerly LDSS-3622) Notice of Decision on Your Medicaid Application
- OHIP-0099 (formerly LDSS-3973) Notice of Decision on Your Medicaid Application (excess income/resources)
- OHIP-0100 (formerly LDSS-4021) Notice of Intent to Change the Contribution Toward Chronic Care
- OHIP-0101 (formerly LDSS-4022) Notice of Intent to Establish a Liability Toward Chronic Care
- OHIP-0102 (formerly LDSS-4321) Explanation of the Excess Income Program

## V. SYSTEM IMPLICATIONS

### A. WMS UPSTATE

Districts must enter codes in two new fields on the WMS Application Registration Screen to transmit an AVS request for SSI-related applicants (Case Type 20). Since it may be necessary to delay the AVS request until appropriate authorization is received, these fields are not required when registering an application. If an application is registered without the new codes, once appropriate authorization is received, the codes are to be entered in the new fields on WAPREG, by completing an application register maintenance transaction. When the daily batch process occurs, the request will be transmitted to the AVS.

The Request Type (RT) field is a single character length field used to specify the type of coverage requested, and to identify certain populations. The field is edited to allow only one of the following codes:

“**C**” (Community) - is used for SSI-related individuals (and spouses, if applicable) seeking coverage for community based services.

“**M**” (Medicaid Buy-In Program for Working People with Disabilities).

“**N**” (Nursing Home) – is used for institutionalized SSI-related individuals (and spouses, if applicable) applying for coverage of nursing home care. If AVS is authorized, the code may also be used for an institutionalized MAGI individual when a transfer of assets look-back period is required.

“O” (COBRA Continuation Coverage).

“S” (Spousal Impoverishment Community) – applies to married individuals who are eligible and participating in a home and community-based waiver or who are appropriate for enrollment in a managed long-term care plan and subject to spousal impoverishment rules.

The second new AVS field is labeled “HS” (Household Size) and allows a numeric entry of 01 (household size of 1) or 02 (household size of 2).

If either the RT field or the HS field is left blank and the other field is not blank, the blank field will blink and a WMS registry screen error message “Examine Blinking Fields” will display. Additionally, if the RT code “S” (Community MLTC or Waiver Spousal) and the HS is equal to 1, both fields will blink with the “Examine Blinking Fields” error message, since RT of “S” is for spousal cases, HS must be 2. If the RT and HS values are entered for any case type other than 20, the RT, HS and Case Type fields will blink with an “Examine Blinking Fields” error. If the RT and HS codes are entered, but either the social security number, or date of birth is left blank, the codes will blink with error. An edit in WMS will prevent submission of an AVS request for individuals under age 19.

## B. NEW YORK CITY

AVS requests for New York City A/Rs will be submitted through the One EDITS system. The Request Type field is a two-character length field to specify the type of coverage requested and to identify certain populations. Request Type codes for applications and requests to convert coverage begin with “E.” For renewals, AVS Request Type codes will begin with an “R.”

“EC/RC” (Community) - is used for SSI-related individuals (and spouses, if applicable) seeking coverage for community-based services.

“EM/RM” (Medicaid Buy-In Program for Working People with Disabilities).

“EN/RN” (Nursing Home) – is used for institutionalized SSI-related individuals (and spouses, if applicable) applying for coverage of nursing home care. If AVS is authorized, the code may also be used for an institutionalized MAGI individual when a transfer of assets look-back period is required.

“ES/RS” (Spousal Impoverishment Community) – applies to married individuals who are eligible and participating in a home and community-based waiver or who are appropriate for enrollment, or are enrolled in a managed long-term care plan and subject to spousal impoverishment rules.

“EV” (Nursing Home Conversion) – is used for individuals who are requesting an increase in coverage from community coverage to nursing home care, or community coverage with no long-term care to community coverage with community-based long-term care.

“EX” (Nursing Home Spousal Conversion) – is used for individuals with a spouse that are requesting an increase in coverage.

“E5” (MLTC Nursing Home Referral) – is used for individuals in the MLTC program who are requesting an increase in coverage to cover nursing home care.

The new Household Size field will be used in New York City.

### **C. NEW AVS TRUST INDICATOR CODES - UPSTATE**

Three new Trust Indicator codes have been developed to indicate that authorization to allow verification of assets through the AVS was not provided or that the A/R was not subject to verification of assets through AVS. These codes are to be used for individuals who have not authorized AVS due to being incompetent or incapacitated, individuals who are eligible for Medicaid Extended Coverage as a NYSPLTC policyholder with Total Asset Protection, or for individuals who are transferred to WMS from the NY State of Health due to turning age 65 and are authorized Categorical Code 10 when the case is opened on WMS. The following Trust Indicator codes must be used to ensure these Medicaid recipients are excluded from the WMS batch file that is sent to the AVS:

U = Unauthorized – used when the trust question on application is blank.

V = Unauthorized with a trust (Y) – used when the response to the trust question is yes.

W = Unauthorized without a trust (N) – used when the response to the trust question is no.

Existing Trust codes “Y” and “N” will remain for purposes of identifying whether there is a trust when an A/R has authorized use of the AVS.

For individuals who are transferred to WMS from the NY State of Health due to turning age 65, once authorization to verify assets through AVS is received on the renewal form, the Trust Indicator code must be changed to “Y” or “N” as appropriate, to ensure the individual is automatically sent to AVS at next renewal.

When receiving or sending Luberto Transfers, Upstate counties should not change this field unless the district has updated information. Cases transferred from Upstate to Upstate should send an existing U, V, or W.

### **D. CLIENT NOTICE SUBSYSTEM (CNS) REASON CODES**

The following new Reason Codes were made available for use when discontinuing or denying Medicaid coverage for lack of authorization to verify assets through the AVS:

UPSTATE:

Reason Code D78 - Discontinue Medicaid, Individual Failed to Submit Signed Authorization for AVS (TT 07 or 08)

Reason Code D79 - Discontinue Medicaid, Individual Revoked Authorization for AVS (TT 07 or 08)

Reason Code D80 - Discontinue Medicaid, Failure to Submit Valid Application (to be used with "H2W" and the immediate referral "H3W" when returned but not valid) - (TT 07 or 08)

Reason Code D81 - Deny Medicaid, Individual Failed to Submit Signed Authorization for AVS

Reason Code D82 - Deny Medicaid, Individual Revoked Authorization for AVS

Reason Code D83 - Deny Medicaid, Failure to Submit Valid Application

**NEW YORK CITY DEFERRAL AND REJECTION CODES:**

Deferral Code A13 – Signature of spouse on authorization to verify resources with financial institutions

Rejection Reason Code H42 – Deny Medicaid: Individual Revoked Authorization for AVS

Rejection Reason Code H48 – Discontinue Medicaid: Individual Revoked Authorization for AVS

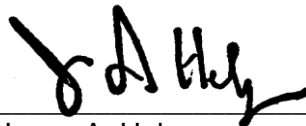
**E. NEW YORK STATE DEPARTMENT OF HEALTH ASSET VERIFICATION SYSTEM USER GUIDE**

The AVS User Guide provides a detailed description of the AVS portal features. Individuals who have been authorized access to the AVS portal can access the User Guide through the Asset Verification System Help Center section of the portal.

**VI. EFFECTIVE DATE**

The provisions of this Administrative Directive are effective with AVS implementation in the local district.

Since NYC will implement use of the AVS in phases, the provisions of this Administrative Directive are effective as each phase is implemented.



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Jason A. Helgerson  
Medicaid Director  
Office of Health Insurance Programs

LISTING OF ATTACHMENTS

Attachment I	DOH-5147 – Submission of Application on Behalf of Applicant
Attachment II	DOH-5148 - Authorization for Verification of Resources (Applicant)
Attachment III	DOH-5149 - Authorization for Verification of Resources (Legal Spouse)
Attachment IV	OHIP-0094 (Rev. 05/15) - Notice of Action on Your Medicaid Application/Benefits (Withdraw/Failure to Provide Authorization for Asset Verification)