TO: Local District Commissioners, Medicaid Directors

FROM: Betty Rice, Director
Division of Consumer and Local District Relations

SUBJECT: Medicaid Resource Documentation Requirements – Full Coverage

EFFECTIVE DATE: Immediately

CONTACT PERSON: Local District Liaison:
Upstate (518) 474-8216 NYC (212) 268-6855

This message is to clarify the resource documentation requirements for full Medicaid coverage.

Prior to implementation of resource attestation (September 20, 2004), social services districts had the option to offer a simplified resource review to establish community Medicaid coverage. Under the simplified resource review, the individual was required to provide documentation of current resources only. Coverage Code 10 was used to identify cases that did not have a full resource review. These individuals were not eligible for Medicaid payment of nursing facility services, including waiver services. If the individual had a spenddown, Coverage Code 02 (Outpatient Only) was used but the individual was still not eligible for payment of nursing facility services, including waiver services.

With implementation of resource attestation, the question has arisen as to whether a 36-month resource look back must be done if a person has been on Medicaid for the past 36 months and has documented current resources at each renewal. It is the Department’s policy that if an individual has been on Medicaid for the past 36 months and has documented current resources at each renewal, the individual has met the resource documentation requirements for full coverage, provided the individual has not created or funded a trust and no prohibited transfer has been made. Trusts require a five year review of any assets transferred to or from the trust. If an individual has only been on Medicaid for two of the past three years, resource documentation must be provided for the third year before the 36-month resource look-back requirement can be met. In this instance, the district would require resource documentation for each month within the third year.

As cases come up for renewal, districts should review the previous Medicaid coverage for the recipient. If the recipient was previously authorized with Full Coverage or Outpatient Only Coverage based on the resource documentation provided, and provides current resource documentation at renewal, the recipient should continue to be authorized with Full Coverage or Outpatient Only Coverage, as appropriate. Districts should pay particular attention to recipients in the community who are receiving waiver services as these individuals require Full Coverage or Outpatient Only Coverage in order to continue to participate in the waiver program.

Questions regarding this resource documentation policy should be addressed to your Medicaid Local District Liaison.