

# MSC E-VISORY

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State of New York Office of Mental Retardation and Developmental Disabilities  
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The MSC E-Visory is an electronic advisory intended to provide timely information to Medicaid Service Coordination Supervisors and their staff.

Questions and comments should be directed to Carol Kriss, MSC Statewide Coordinator via e-mail: Carol.Kriss@omr.state.ny.us

Each E-Visory has pertinent information on programs and services available to individuals receiving Medicaid Service Coordination (MSC). Announcements about MSC training, conferences and meetings appear regularly in issues of the MSC E-Visory. Please forward this issue to all Medicaid Service Coordinators and MSC Supervisors.

## **In This Issue:**

### Training Opportunities

Brooklyn Developmental Disabilities Council's 20<sup>th</sup> Annual Family Support Fair, Monday May 18<sup>th</sup> 2009, 9:30 am to 2:30 pm, Brooklyn College, Student Union Building, Brooklyn, NY. Cost: \$12 for professionals; free to consumers and family members. See separately attached flyer and registration form for details.

Save the Date: RRTI's 3<sup>rd</sup> Annual Service Coordination Leadership Institute: Team Management, July 14, 2009, 9am-4:30pm, Century House, Latham, NY. See separately attached flyer; more details to follow.

### Family Health Plus: Follow-up from the recent MSC Supervisors Video Conference:

- Q. Does the CBIC card (commonly referred to as the Medicaid card) have anything on it to distinguish a person who has Family Health Plus coverage?  
A. There is no difference in the cards. It was done this way specifically to protect the individual card holder.

### Selecting the Correct Medicaid Coverage Option for Home and Community Based Services (HCBS) Waiver Enrollees

The following article provides information on current eligibility documentation requirements for individuals applying for or renewing Medicaid coverage necessary when enrolled in OMRDD's HCBS Waiver. As a result of this clarification from New York State Department of Health (NYS DOH), individuals seeking Medicaid coverage that will support HCBS Waiver enrollment are only required to document current resources and will not be asked about transfers of resources prior to their application for this type of coverage. Local Medicaid districts have been advised of the change. Details on community coverage and the list of services it supports are included in the article.

## **Selecting the Correct Medicaid Coverage Option for Home and Community Based Waiver (HCBS) Enrollees**

This message will serve to clarify current eligibility requirements for individuals seeking to receive the appropriate level of Medicaid coverage when enrolled in the Office of Mental Retardation and Developmental Disabilities (OMRDD) Home and Community Based Services (HCBS) Waiver. Please share with appropriate staff.

Previously service providers were advised that individuals seeking to enroll in the HCBS Waiver must request "Full Coverage" (Medicaid Coverage for all Covered Care and Services - Coverage Code 01) from their responsible Medicaid district in order to support payment for Waiver services. In order to qualify for this level of Medicaid coverage individuals are required to provide documentation of their resources for up to 60 months prior to the application date to ensure that they have not engaged in any Medicaid disqualifying transfers of resources.

The New York State Department of Health has recently clarified the documentation requirements for individuals applying for and renewing Medicaid coverage. As a result, individuals seeking Medicaid coverage that will support HCBS Waiver enrollment (and payment of HCBS Waiver services) will only be required to document current resources and will not be asked about transfers of resources prior to their application for this type of coverage. Local Medicaid districts have been advised of this change and will no longer provide individuals with "Full Coverage" unless the individual requires services appropriate to this coverage level (e.g. Intermediate Care Facility services or Nursing Home care) and has complied with the documentation requirements necessary for this level of coverage.

Effective immediately, HCBS Waiver participants must request the following types of Medicaid coverage to pay for waiver services:

- Community Coverage with Community Based Long Term Care (Medicaid Coverage Code 19)

or

- Outpatient Coverage with Community Based Long Term Care – (Medicaid Coverage Code 21). This is coverage for persons who have spenddowns.

**Note:** Community Coverage with Long Term Care will pay for medical, dental and clinic services. It will also pay for Medicaid Service Coordination. Community Coverage with Community Based Long Term Care coverage also supports payment for the following:

Community-Based Long-Term Care Services

- Adult day health care (medical model)
- Limited licensed home care
- Certified home health agency (CHHA)
- Hospice in the community
- Hospice residence program
- Personal care services
- Personal emergency response services
- Private duty nursing
- Consumer directed personal assistance program
- Assisted living program (ALP)
- Managed long-term care in the community
- Residential treatment facility
- Home and community-based services waiver programs, including:
  - Long-Term Home Health Care Program
  - Traumatic Brain Injury Waiver Program
  - Care at Home Waiver Program
  - Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program

**NOTE: Individuals seeking ICF or nursing home services must continue to request “Full Coverage” (Coverage Code 01) and must document their resources for up to 60 months prior to the application.**

If an individual in receipt of “Community Coverage with Community Based Long Term Care” or “Outpatient Coverage with Community Based Long Term Care” requires ICF or nursing home placement at a future date, the local district will request documentation of the individual's prior resources, but may not require the full look back based on previous documentation that has already been provided. For example, if a person has been in receipt of “Community Coverage with Community Based Long Term Care” coverage and has documented his/her current resources for three years prior to the application for “Full Coverage” but must document resources for 60 months prior to the application in order to obtain “Full Coverage”, the applicant may only be asked to document resources for the remaining undocumented 24 months.

Currently, an individual applying for “Community Coverage with Community Based Long Term Care” (Coverage Code 19) or “Outpatient Coverage with Community Based Long Term Care” (Coverage Code 21) must provide documentation of current resources at each Medicaid renewal and inform the local Medicaid districts that s/he requires Community Based Long Term Care to ensure that s/he continues to receive the level of coverage that pays for Waiver services.

Local Medicaid districts have been instructed to maintain Coverage Code 01 for Waiver participants who currently have “Full Medicaid Coverage” unless the individual had only been given this level of coverage to support payment for Waiver services prior to the recent activation of payment edits which support payment for Waiver services for individuals with Coverage Code 19 or 21. For these individuals, coverage will be downgraded to the appropriate level at the time of their next Medicaid renewal or other change in eligibility.

The Department of Health has implemented programming to support payment of Waiver services for individuals with “Community Coverage with Community Based Long Term Care” or “Outpatient Coverage with Community Based Long Term Care” coverage. The implementation of the appropriate programming now permits payment of Waiver services for individuals with these levels of coverage.

If you have any questions, please contact Marge Ciaccio by telephone at (518) 402-4339 or by e-mail to [Marjorie.Ciaccio@omr.state.ny.us](mailto:Marjorie.Ciaccio@omr.state.ny.us).