

OMRDD Benefit-Related Memorandum

TO: Executive Directors, ICF/DD Agencies
Executive Directors, HCBS Agencies
Executive Directors, MSC Vendors
Provider Associations

FROM: Lisa M. Kagan
Associate Commissioner

DATE: August 30, 2004

SUBJECT: Selecting the Correct Medicaid Coverage Option for OMRDD Home and Community Based Waiver Services and ICF/DD Placement

This is to inform you that starting in September 2004, individuals seeking to enroll in Medicaid will be asked to specify the type of Medicaid for which they are applying. There are three options:

- o "Community Coverage Without Long-term Care"

- o "Community Coverage With Community Based Long-term Care"

- o "Medicaid Coverage For All Covered Care and Services"

Individuals seeking Medicaid funding for OMRDD Home and Community Based Waiver Services (e.g. IRA, day habilitation) or ICF/DD placement must choose "Medicaid Coverage for All Covered Care and Services." For this type of Medicaid, application form LDSS-2921 must be completed.

If the wrong Medicaid coverage is selected, providers of waiver services and ICF/DD care will not be paid by the Medicaid Management Information System (MMIS).

We do not expect that this change will affect individuals with existing Medicaid coverage that pays for waiver services or ICF/DD care. Changes in these Medicaid "cases" should be automatically carried out by the system. However, we will continue to be in touch with the NYS Department of Health on this issue and will notify you of any action necessary.

Documentation Requirements

When applying for "Medicaid Coverage for All Covered Care and Services," the applicant must provide documentation of resources to ensure that there has been no disqualifying transfer of resources in a 36-month look back period. Where a trust has been created, the look back period is 60 months. Please note that this look back documentation requirement does not represent a change in the Medicaid application process currently in existence for OMRDD waiver enrollees and ICF/DD residents. The application form itself has not changed either.

Dealing with Incorrect Medicaid-Coverage Selections

If an individual seeking OMRDD Home and Community Based Waiver services or ICF/DD placement selects the wrong Medicaid coverage option, he/she should return to the Local Social Services District Office (HRA in New York City) to change the application. Again, it is the selection of the "Medicaid Coverage for All Covered Care and Services" option that will allow the person to receive Medicaid Home and Community Based Waiver services or ICF/DD care. *The request for a change in the category of Medicaid coverage must be conducted as quickly as possible.* When the Medicaid recipient refiles for the correct type of coverage, the new application only allows for three months of retroactive coverage under the new Medicaid category. For example, if an individual refiles in October 2005, waiver services for the individual claimed prior to July 2005 will not be paid by the Medicaid Management Information System (MMIS).

Thus, fact action in making the change to the correct Medicaid coverage option is imperative!

Technical Assistance

A State Department of Health Fact Sheet on the above described change is [attached](#). Local Social Services Districts will provide the Fact Sheet to all applicants as part of the face-to-face interview required for Medicaid eligibility determinations.

Additionally, OMRDD's [local Revenue Support Field Offices \(RSFO\)](#) are available to assist OMRDD providers, consumers and advocates. This assistance includes corrective actions necessary where the Home and Community Based Waiver services or ICF/DD provider has received a denied claim for a service for MMIS. A list of RSFO offices can be obtained by calling OMRDD Field Operations at (518) 402-4339. It is also available on the OMRDD website, <http://www.opwdd.ny.gov>. If you have any questions, you may contact Kevin Patricia, Director of Field Operations, at the above telephone number.

Thank you for your help in distributing this information to others in the OMRDD service community. It is critical that people requiring OMRDD Home and Community Based Waiver services or ICF/DD placement select the "Medicaid Coverage for All Covered Care and Services" option when enrolling in the Medicaid program.

Please share with appropriate staff.

Attachment I

EXPLANATION OF THE RESOURCE DOCUMENTATION REQUIREMENTS FOR MEDICAID

If you want Medicaid coverage of certain care and services, you must submit proof of your resources. The following explains the resource information that must be submitted in order to be eligible for coverage of certain care and services.

When you apply for Medicaid, you will be asked to choose one of the following:

1. community coverage *without* long-term care;
2. community coverage *with* community-based long-term care; or

3. Medicaid coverage for *all* covered care and services.

Note: Pregnant women, children under age one, and children between the ages of one and 19, who have incomes at or below the applicable federal poverty level, do not need to provide proof of their resources in order to qualify for Medicaid coverage for all care and services.

1. **Community Coverage Without Long-Term Care**

Applicants/recipients who do *not* need nursing facility services or community-based long-term care may attest to the amount of their resources. If we find that you are eligible under this simplified review, you will get Medicaid coverage but *not* coverage for nursing facility services or community-based long-term care.

If at some time you need nursing facility or community-based long-term care services, we will need to look at your resources before Medicaid can cover these services.

People who attest to the amount of their resources are eligible for short-term rehabilitation services. Short-term rehabilitation includes one commencement/admission in a 12-month period of up to 29 consecutive days of: nursing home care and certified home health care.

If we find the information you report is different from the information we get from investigating what you reported, you will be requested to give us proof of your resources.

2. Community Coverage With Community-Based Long-Term Care includes

- o Adult day health care
- o Limited licensed home care
- o Certified home health agency services
- o Hospice in the community
- o Hospice residence program
- o Personal care services
- o Personal emergency response services
- o Private duty nursing
- o Residential treatment facility
- o Consumer directed personal assistance program
- o Assisted living program
- o Managed long-term care in the community
- o Home and community-based services waiver programs

To be eligible for community coverage *with* community-based long-term care services, you must give us proof of your current resources. If we find that you are eligible, you will *get* Medicaid covered care and services that include community-based long-term care services, *but* you will *not get coverage* for nursing facility services, except for short-term rehabilitation. *If* you later need nursing facility services, we will need to look at your resources for up to the past 36 months (60 months for trusts) before Medicaid can cover these services.

3. Medicaid Coverage for All Covered Care and Services includes

- o Nursing home care
- o Nursing home care provided in a hospital
- o Home and community-based waiver services
- o Hospice in a nursing home
- o Managed long-term, care in a nursing home
- o Intermediate care facility

To be eligible for these services, we must review your resources for up to 36 months (60 months for trusts/12 months for single individuals and childless couples) prior to your application.

If we find that you are eligible, you will *get all* Medicaid covered care and services including the nursing facility services listed above and the community-based long-term care services listed under.

Applicants/recipients who do not need nursing facility services now may choose to apply only for Community Coverage with Community-Based Long-Term Care or Community-Coverage *without* Long-Term Care.

If you become in need of a service for which you have *not* received *coverage*, contact your worker immediately for assistance.