

+-----+
 | INFORMATIONAL LETTER |
 +-----+

TRANSMITTAL: 91 INF-71

TO: Commissioners of
 Social Services

DIVISION: Medical
 Assistance

DATE: December 23, 1991

SUBJECT: Questions and Answers from the Spring 1991 Medical
 Assistance Regional Meetings

SUGGESTED

DISTRIBUTION: Medical Assistance Staff
 Fair Hearing Staff
 Income Maintenance Staff
 Designated Pregnancy Workers
 Child Support Enforcement Staff
 Third Party Staff
 Staff Development Coordinators

CONTACT PERSON: MA Eligibility Representative at 1-800-342-3715,
 ext. 3-7581, MA New York City Representative at
 (212) 417-4853

ATTACHMENTS: Attachment I - Questions and Answers
 (available on-line)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
91 ADM-27					
91 ADM-22					
91 ADM-18					
91 ADM-17					
90 ADM-30					
90 ADM-9					

Date December 23, 1991

Trans. No. 91 INF-71

Page No. 2

The purpose of this letter is to provide answers to questions that were raised during the Medical Assistance Regional Meetings held during March - April, 1991. Please be aware that all case specific situations and circumstances may not be addressed by the answers given here. You may call the number on page one of this letter for further clarification.

Jo-Ann A. Costantino
Deputy Commissioner
Division of Medical Assistance

NEW LEGISLATION

1. QUESTION

Are taxes a deduction from taxable pensions when budgeting individuals residing in nursing homes?

ANSWER

No. Taxes are no longer allowed as a deduction for anyone with earned or unearned income. Since the individual does not have the money available to pay the contribution to care (NAMI), he or she can petition the payer of the pension to reduce or eliminate the amount of taxes deducted from the check. Note: the State and federal government are currently involved in litigation on this issue.

2. QUESTION

Are garnishee amounts allowed as deductions?

ANSWER

No. Only federally mandated deductions such as health insurance premiums, \$90 work related expense, \$30 & 1/3, \$65 & 1/2, and child care expenses are allowed.

3. QUESTION

Is court ordered support paid by stepparents exempt from income when determining the stepparent's eligibility?

ANSWER

No. Court ordered support is a deduction only when: deeming, budgeting spousal cases, or determining the requested income contribution from a non-applying spouse living apart from an SSI-related A/R.

4. QUESTION

When using the stepparent's available income in determining a stepchild's eligibility, is court ordered support paid by the stepparent a deduction?

ANSWER

No. Only the income of the stepparent that is actually made available to the stepchild is counted in determining the child's eligibility.

5. QUESTION

When a child turns six years of age, an AFA (102 Individual Turning six) is generated on the PA case. With the recent changes in eligibility for infants and children should MA cases also generate this AFA? Will AFA codes be available for infants turning one year of age?

ANSWER

No. However, a systems request has been submitted to support AFA codes for infants turning one year of age and children turning six years of age but this is not yet available.

EXPANDED ELIGIBILITY

6. QUESTION

What happens to a TMA case if the family moves and their new location is unknown? What if they move out of state?

ANSWER

This should be treated as any other case and should be closed.

PREGNANCY/PCAP

7. QUESTION

Is a change from MA Coverage Code 13 (Presumptive Eligibility - Prenatal Care A) to Code 15 (Prenatal) a downgrade?

ANSWER

No. However, a change from Code 15 to Code 13 could result in a downgrade error.

8. QUESTION

How does IV-D requirement policy change for pregnant women affect a woman's ability to voluntarily establish paternity prior to the infant's birth?

ANSWER

According to OBRA provisions MA cannot refer a pregnant woman to IV-D. This includes referrals to establish paternity for the unborn or for the pregnant woman's other children. She may contact IV-D on her own but in no way can it be a condition of eligibility.

9. QUESTION

Some Qualified PCAP providers are refusing to accept clients for presumptive eligibility if they state they do not plan on following through with that provider for the entire pregnancy. Do the providers have a right to do this?

ANSWER

Yes. They are treated like any other providers.

10. QUESTION

What can be done about PCAPs which do not "offer" to represent clients?

ANSWER

"Enhanced" services are included in the Health Department's payments to providers. If the appropriate services are not being offered, the Health Department should be notified.

11. QUESTION

GIS message 91MA007 (2/14/91) stated that when a pregnant woman under 21 applies for MA the income and resources of her parents cannot be counted. Can this policy be applied in the three month retroactive period?

ANSWER

Yes, provided the individual is pregnant, the disregarding of parental income may be applied for the three month retroactive period. However, it cannot be applied prior to January 1, 1991.

12. QUESTION

If the pregnant client refuses to give information regarding health insurance, is the health insurance considered a resource? If so, in cases where resources are exempt is health insurance also exempt?

ANSWER

The pursuit of health insurance is considered a condition of eligibility. Therefore, except for good cause (e.g., a pregnant minor who is afraid to tell her parents), clients who refuse to give this information may be ineligible for MA.

EXCESS RESOURCES/INCOME

13. QUESTION

If an individual pays a medical bill in a month where medical bills are less than the excess resource amount, can the bill be carried forward into a future month and then used to reduce his or her excess income?

ANSWER

Since the bill was paid in a month in which the client was ineligible, he/she would not be allowed to use the bill later to reduce excess income or excess resources. If the bill was unpaid or paid in the month eligibility is established it could be applied.

14. QUESTION

For spousal situations, does the 12:01 resource snapshot policy apply?

ANSWER

Yes, the resources the couple have as of the first of the month coverage is requested are considered when determining their total countable resources.

15. QUESTION

If an applicant is residing in a medical institution and a burial agreement cannot be established within 10 days, can anything be done to give the burial fund exemption?

ANSWER

If there is no prepaid funeral agreement at the end of the ten day notice period, the \$1,500 burial FUND may still be allowed but not funds for unpurchased burial SPACE items.

Burial funds may be combined with non-burial related assets if there is an impediment to separating the funds. For example, an extension can be allowed if an applicant is physically or mentally incapacitated and unable to authorize separation of assets to establish the \$1,500 burial fund.

Funds for burial SPACE items may only be exempt if an applicant fully prepaays for the burial space items within the ten day notice period. Eligibility workers should explain funeral agreement and burial space provisions at the time of the interview. This allows the applicant or representative time to make the necessary arrangements and present the district with a copy of the agreement.

16. QUESTION

A portion of an individual's excess resources are applied toward a medical bill. The client then incurs another medical bill from a provider who does not accept Medicaid. Can this bill be used to offset other excess resources?

ANSWER

Yes. Any viable unpaid bill may be used to offset excess resources. (See 91 ADM-17)

17. QUESTION

A third party other than health insurance pays a medical bill for an MA applicant. Can the bill be used to reduce the individual's excess resources?

ANSWER

It depends on who the third party payer is. If it is a public program of the state (other than Medicaid or other DSS programs) the bill can be used to offset excess resources. The bill cannot be used for all other third party payers.

18. QUESTION

A client recertifies for MA and is found to have excess resources in a retroactive period. Can a client request that his or her case be closed and reapply as a new applicant to establish a retroactive burial fund agreement?

ANSWER

This will not be necessary since the individual was eligible anyway. If, however, the district was contemplating recovery and medical expenses were under \$1,500, the burial fund could be applied.

19. QUESTION

Can all health insurance premiums paid by a public agency be used toward a spenddown?

ANSWER

No. Any premium paid by a DSS program cannot be used; however, any premium paid by another public program can be used.

20. QUESTION

If resources are removed from a savings account are they considered income in the month they are removed or do they remain as a resource.

ANSWER

Monies taken from a regular savings account are not income. However, monies removed from a pension fund or trust account are income in the month received.

21. QUESTION

When are medical bills paid by public programs no longer used to offset excess resources?

ANSWER

As stated in 91 ADM-17, medical bills paid by public programs will be used to reduce excess resources and will be considered viable for up to six consecutive months. This six month maximum lasts until the end of the certification period in which the public program paid the bill. This period must not exceed 6 months.

UTILIZATION THRESHOLD

22. QUESTION

When a UT client changes category from HR-related to ADC-related and then back again do we begin the threshold count all over again?

ANSWER

No. The benefit year does not change regardless of whether the client changes category or goes on and off Medical Assistance during this period. The client, however, is eligible for the higher number of pharmacy items regardless of the category change during that benefit year.

Note: If the client is not on MA for 24 continuous months, the benefit year would begin again.

CHIP

23. QUESTION

Is the CHIP premium paid to the contract agency or the New York State Department of Health?

ANSWER

The CHIP premium is paid to the contract agency.

24. QUESTION

How does the district know if the individual is on CHIP?

ANSWER

As with any other third party health insurance, the district must ask if the family has any health insurance coverage.

25. QUESTION

Can we use the CHIP subsidy/premium payment for a child to reduce the rest of the family's excess. If so, how does this policy affect MEHLER rules.

ANSWER

The CHIP subsidy/premium payment for a child can reduce the family's excess income. This includes a non-applying child. This policy does not affect MEHLER rules.

26. QUESTION

If the CHIP subsidy is high, say \$60, and the family's excess is \$10 will the family obtain six months of full MA coverage? Do we continue to add months of credit prospectively as subsequent payments are made?

ANSWER

The annual subsidy for one child is currently between \$550-\$650. If the monthly CHIP subsidy payment equals the family's excess for six months, the family can be authorized for six months of full coverage. At no time should more months be authorized prospectively than the certification period. If the child(ren) in receipt of the CHIP subsidy is not included in the MA application, the CHIP subsidy should continue. The CHIP subsidy for the subsequent month would reduce the family's excess to allow for an additional six months of full MA coverage. If this initial certification was for six months, the subsidy for the subsequent month would be credited to the family's excess at the time of recertification.

27. QUESTION

How will the districts know the amount of the CHIP subsidy?

ANSWER

In order to determine the amount of the CHIP subsidy, the district must contact the CHIP contract agency. The Department will provide a list of CHIP contracted agencies when available.

28. QUESTION

What happens if an MA application is made for a CHIP eligible child's retroactive hospital bill and the bill is six times greater than the premium. Do they obtain full coverage and subsequently become ineligible for CHIP?

ANSWER

If an application is made for MA coverage of the CHIP eligible child's hospital bill in the three month retroactive period and the CHIP subsidy payments for the same period were equal to or greater than the six month spenddown amount, MA coverage is available for the hospitalization. When the child is determined MA eligible the social services district must contact the CHIP contract agency. The contract agency in turn notifies the client that the subsidy payment will be discontinued.

29. QUESTION

Can the social services district pay the CHIP premium and co-payment if three children are on CHIP, the remainder of the family is MA eligible, and the income for the three children is not counted in determining the family's eligibility (MEHLER).

ANSWER

The social services district cannot pay the CHIP premium or co-payment under any circumstances.

30. QUESTION

How can we prevent flip-flopping between CHIP and MA?

ANSWER

A child cannot be CHIP eligible if he or she is in receipt of MA. The client who would be eligible for both programs has the choice of enrolling in CHIP or receiving MA. A condition of CHIP eligibility is that the child is not in receipt of MA. If the family chooses MA for the child, the CHIP subsidy must be stopped.

NEW PROGRAMS

31. QUESTION

Is a published list of PPAC providers available to districts?

ANSWER

The Child Teen Health Plan Coordinator has a list of PPAC participating providers. This list is updated every four months.

32. QUESTION

Under the new outreach program where hospitals can take applications for pregnant women and children, what happens when the county uses out-of-state hospitals and clinics?

ANSWER

Districts are not required nor expected to provide outreach activities at out-of-state hospitals and clinics.