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| <p style="text-align: center;"><b>OFFICE OF MEDICAID MANAGEMENT<br/>LOCAL COMMISSIONERS MEMORANDUM</b></p> |
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**Transmittal No:** 97 OMM LCM-3

**Date:** July 10, 1997

**DEPARTMENT OF HEALTH  
Office of Medicaid Management**

**TO:** Local District Commissioners

**SUBJECT:** Medicaid Eligibility for New York State Partnership  
Policyholders

**ATTACHMENTS:** Partnership General Information Packets (2)  
(not available on-line)

90-Day Notice of Medicaid Qualifying Status  
(available on-line)

The purpose of this Local Commissioners Memorandum (LCM) is to provide general information on the New York State Partnership for Long-Term Care program, and to advise social services districts of the extended Medicaid coverage that is available to policyholders once certain benefits are exhausted. It is anticipated that policyholders may be applying for Medicaid as early as June 1997. It is, therefore, important for social services districts to become familiar with the eligibility rules that apply to these applicants.

**The New York State Partnership for Long Term Care**

New York State has been authorized to establish a Partnership for Long-Term Care (Partnership) program to assist residents of New York in planning for the cost of long-term care. This program, funded in part by a grant from the Robert Wood Johnson Foundation, promotes the availability of State-approved, long-term care insurance policies sold through private insurance companies.

Partnership long-term care insurance policies contain unique features and must be approved for the Partnership program by the Insurance Department of the State of New York. Under the New York State Partnership for Long-Term Care, people are able to afford their own care during the private terms of the insurance coverage without the need for impoverishment and dependency on Medicaid.

The goals of the Partnership are financial independence and protection for consumers, and cost-savings to the Medicaid program for long-term care for Partnership policyholders who might depend on Medicaid in the absence of such insurance. Individuals meet their responsibility by purchasing a Partnership long-term care insurance policy and keeping it in effect. The State participates by protecting the individual against the cost of extended-care, when needed, through the Medicaid program.

### **How the Partnership Works**

Medicaid coverage under the New York State Partnership is called Medicaid extended coverage. Eligibility for Medicaid extended coverage is based upon time and income. Individuals who purchase Partnership policies and subsequently exhaust three (3) years of nursing home benefits (3 years of nursing home days) or the equivalent of six (6) years of home care days (2 home care days counting as 1 nursing home day) may apply for Medicaid extended coverage even if benefits are still available under a Partnership policy, so long as they have exhausted the three years of nursing home equivalent benefits. In 1997, minimum Partnership policy benefits include \$122/day for nursing home care and \$61/day for home care. Those who live in areas of the State with higher long-term care costs are encouraged to purchase coverage beyond the minimum amounts. All Partnership policies include five percent compounded annual increases in their nursing home and home care benefits.

The New York State Partnership permits a qualified applicant to apply for and receive Medicaid coverage regardless of the type or amount of resources he or she has. However, all income rules in effect at the time of application for Medicaid apply.

**NOTE:** Although an individual may utilize his or her York State Partnership insurance in another state, the extended Medicaid coverage (no resource test) is only available in New York State. Provided an individual is not placed in a New York State institution by another state, or by a public or private organization contracting with the other state for such purposes, an individual would become a resident of New York State upon entering the State. An individual cannot be denied Medicaid because he or she did not establish residence in the State before entering an institution.

### **Identifying a Qualified Partnership Policyholder**

The Partnership Office in the Office of Medicaid Management is responsible for tracking the use of benefits of a Partnership policyholder as reported by the policyholder's insurance company. When a Partnership policyholder exhausts benefits to the point where qualifying status will be attained within 90 days of benefit utilization, the insurance company will notify the policyholder that a Medicaid application should be initiated. The Partnership Office will also receive a copy of the notice from the insurance company. Attached is an example of the 90-day notice that will

be sent. Actual notices will be produced on company letterhead. The notice will serve as verification to the social services district that the applicant is a Partnership policyholder who is

about to achieve qualifying status. However, the earliest month that Medicaid eligibility may be determined without regard to resources will depend on the date on which the policyholder exhausts three years (1,095 days) of nursing home care or six years (2,190 days) of home care, or a combination of the two.

### **Medicaid Eligibility for Qualified Partnership Policyholders**

In general, the Medicaid eligibility process for qualified Partnership policyholders is the same as for other Medicaid applicants with one important exception, the treatment and documentation of resources.

The resources of qualified Partnership policyholders are exempt from consideration in determining Medicaid eligibility. Therefore, it is not necessary to collect and/or document information on an individual's resources or the resources of his or her spouse except to the extent that such information documents income derived from such resources (i.e., a bank statement showing interest, statement from a financial broker indicating dividends earned, etc.) Social services districts are encouraged to minimize the scope of inquiry into the resources of such individuals unless such inquiries are directly related to current income or anticipated income.

It should be noted that when completing the Medicaid application/recertification, the resource areas do not need to be completed. Any income derived from a resource is to be listed under the income section of the application/recertification form. Similarly, when entering information on MBL, resources do not need to be entered. Social services districts should use an individual's income tax return together with information obtained through the 1099 match process and Resource File Integration to assist in determining whether the individual's income streams are accounted for.

As previously advised in Administrative Directive 96 ADM-8, "OBRA '93 Provisions on Transfers and Trusts", since resources are exempt from consideration in determining a qualified policyholder's Medicaid eligibility, the transfer of resources provisions (i.e., look-back period and penalty period) do not apply. However, since income is not exempt, a transfer of a lump sum income payment or a stream of income during the look-back period, may result in a transfer penalty.

**NOTE:** When an exempt resource that generates income is transferred, no penalty may be imposed.

In addition, in accordance with Administrative Directive 92 ADM-53, "Medical Assistance Liens and Recoveries", no lien may be imposed on the real property of an institutionalized individual, who is a qualified Partnership policyholder, for Medicaid correctly paid or to be paid.

Furthermore, no recovery may be made from the estate of a qualified Partnership policyholder for Medicaid correctly paid.

To assess the impact of the Partnership for Long-Term Care program, the Department will track the Medicaid utilization of qualified Partnership policyholders.

If you have any questions regarding the Medicaid coverage/eligibility determination that must be provided under the terms of the Partnership program, please contact Wendy Butz or Elsie Kirk, of my staff, at (518) 473-5500 or 473-5509, respectively. For other questions about the New York State Partnership for Long-Term Care program, please contact the Partnership Office at (518) 473-7705.

Ann Clemency Kohler  
Director  
Office of Medicaid Management

Enclosures

## 90-DAY NOTICE OF MEDICAID QUALIFYING STATUS

Dear Partnership Policyholder:

According to our records, you will meet the minimum benefit duration requirement of your New York State Partnership for Long Term Care Insurance Policy (i.e., 1,095 days of nursing home care, or 2,190 days of home care or a combination of the two) within approximately 90 days of continued benefit use, at which time you may qualify for Medicaid Extended Coverage under the Partnership. As a Qualifying Partnership Policyholder (QPP) under this program, you can apply for Medicaid Extended Coverage of your continuing long-term care needs without regard to your assets.

To apply for Medicaid Extended Coverage, you must contact the Local Department of Social Services (LDSS) in the county where you reside. If you are residing in a nursing home, your county of residence for Medicaid purposes should, in most instances, be where you were residing prior to your admission. The LDSS is responsible for conducting the Medicaid eligibility process. To facilitate the transition in payer sources for your care, you are encouraged to contact your LDSS and initiate the Medicaid eligibility process as soon as possible. The telephone number of the appropriate LDSS office appears in the blue pages of your telephone directory under County Government, Department of Social Services.

This notice will serve as verification to the LDSS that you are expected to attain QPP status within 90 days. The precise date on which Medicaid funding may commence will depend on:

- o the date you apply for Medicaid;
- o the date on which you exhaust three years (1,095 days) of nursing home care or six years (2,190 days) of home care or a combination of the two; and
- o if you are found otherwise eligible for Medicaid, for example, you are income-eligible for Medicaid.

The approximate date when you will meet the minimum benefit duration requirement of your New York State Partnership Long Term Care Insurance Policy is listed below; you will need to provide it to your LDSS. In addition, as part of the Medicaid application process, the LDSS will request that you provide information pertaining to your financial status, particularly your income. While assets are exempt from consideration in determining Medicaid eligibility, the LDSS will ask you to document your assets to the extent that they produce income.

Policyholder:

SSN:

Date of 90-Day Notice:

Approximate date of satisfying minimum benefit duration requirement:

Insurer Toll-Free Telephone Number for inquiries: