HCANJ
Medicaid Eligibility Determinations
Statutory/regulatory provisions that make it faster in other states.

Some of what makes the eligibility determination process faster in other states compared to New Jersey can be attributed to statutory or regulatory provisions. While not an exhaustive analysis and limited to a few nearby states where eligibility determinations are made faster than in New Jersey, the following offers some statutory/regulatory provision changes that New Jersey should consider adopting to speed up the process here.

Initial Month of Eligibility – Spend Down

One thing that differentiates other states from New Jersey in making Medicaid eligibility determinations faster is how "spend down"/counting resources during the first month of eligibility is treated.

New Jersey requires that debt be paid and assets actually be reduced to the eligibility limit *before* the "first day of the month" of eligibility (N.J.A.C. 10:71-4.1 and 4.5) (See attached "New Jersey Spend Down")

Other states regard assets dedicated to the payment of outstanding debts (e.g., medical expenses) as excludable (see attached New York, Connecticut and Pennsylvania "Spend Down" rules):

New York -- 18 CRR-NY 368.4

Connecticut -- Connecticut Department of Social Services Uniform Policy Manual – Sec.4005.15

Pennsylvania -- 58 Pa. Code § 178.1. and Pennsylvania Department of Public Welfare – OIM Policy Manual Sec. 340.12

Applicant Pending Guardianship

Technically in New Jersey, once a guardianship application is filed, the Medicaid application can also be filed. However, facilities are being told by Medicaid to submit a Medicaid application *only after* the guardianship has been approved (resulting in lost eligibility periods).

New York State provides for an easement in place for incapacitated applicants seeking nursing home Medicaid eligibility. That easement allows for a presumptively incapacitated individual seeking such nursing home Medicaid coverage to be granted eligibility without a full resource or income review, because resources, income, documentation and information pertaining to that individual's eligibility are all deemed to be unavailable because of the individual's incapacity.

New York State Administrative Code (18 NYCRR §360-4.4(b)) lists available resources as "all resources *in the control of* the applicant/recipient. It also includes any resources in the control of *anyone acting on the applicant's/recipient's behalf* such as a guardian, conservator, representative, or committee". Since resources are not within the control of an incapacitated applicant/recipient or a guardian prior to being appointed and commissioned, the resources are unavailable while someone is Medicaid pending guardianship.

New York Department of Health Administrative Directive 03 OMM/ADM-1 (attached) states that with regard to the treatment of resources (page 12, Section VI A.2.):

> "From the time the petition is filed until the court appoints a guardian, or the guardianship proceeding is otherwise resolved, the resources of the individual *are not considered available*, and therefore would *not result in ineligibility for Medicaid.* Once the guardian is appointed, the resources of the individual are considered available and may result in ineligibility until incurred medical expenses are at least equal to the amount of excess resources."

The New York State Medicaid Reference Guide (MRG) at Pages 502-503 (attached) states that:

> "If an A/R (Medicaid applicant/recipient) is alleged to be incapable of managing his/her own finances, and there is no one with the legal authority to make decisions concerning the A/R's income/resources, the A/R's income/resources are considered unavailable from the time a petition to appoint a guardian is filed until the court appoints a guardian."

Failure to Provide Documentation (Evidence)

New Jersey infrequently considers granting eligibility even if the documentation is provided prior to or at the appeal hearing. This has apparently resulted from limitations to the review of evidence resulting from a very strict interpretation of New Jersey Administrative Procedures for Medicaid Applicant/Recipient Fair Hearings (N.J.A.C. 1:10B-10.1 Discovery) (attached – New Jersey Evidence).

In Pennsylvania, when there is a denial because of "failure to provide documentation" and an appeal is requested, if the applicant sends in the documentation prior to or at the fair hearing, the case will be reopened and eligibility will be re-determined based on the new documents received for the original begin pay date requested. Pennsylvania rules for Medicaid denial appeal hearings guarantee the right of the appellant or his representative " To present evidence on his own behalf, to bring witnesses or documents he deems necessary, and to confront and cross-examine witnesses the county office, administering agency or social service provider will produce to support its decision or action." (55 Pa. Code § 275.3)(attached - Pennsylvania Evidence)

General Failure to Fulfill Federal and New Jersey Statutory Mandate of Timely Processing of Applications

Other submissions by this Association include statistics supporting the fact that, in too many cases, the processing times for Medicaid long term care applications in New Jersey do not meet federal requirements and are significantly longer than those of other states.

Federal regulation (42 CFR §435.912 Timely determination of eligibility) mandates that:

> The agency must establish time standards for determining eligibility and inform the applicant of what they are. These standards may not exceed—
>
> (1) Ninety days for applicants who apply for Medicaid on the basis of disability; and
>
> (2) Forty-five days for all other applicants.
>
> (b) The time standards must cover the period from the date of application to the date the agency mails notice of its decision to the applicant.

New Jersey Statute requires that "County welfare agency to provide adequate employees to determine Medicaid eligibility" (N.J.S.A. 30:4D-7a). Statute also requires that the department shall assure "That the processing of applications shall be simplified to the end that medical benefits shall be furnished to recipients as soon as possible." (N.J.S.A. 30:4D-15 (b)).

Regardless of whether or not the counties are providing adequate employees to determine Medicaid eligibility and whether or not the State lacks resources to ensure that county resources are being employed efficiently and productively, the fact remains that the federally prescribed timeframe for eligibility determinations of prospective long term care beneficiaries is not being met in New Jersey.

Consideration of the other states' statutory and regulatory provisions referenced above offer a partial solution to expediting the Medicaid eligibility determination process here in New Jersey. Other factors to be considered are reigning in the discretionary processing decisions made across the 21 counties. For example, the State should consideration prescribing through regulation one standard "checklist" that counties must provide to applicants know precisely what financial information should be submitted when filing their application. It would go a long way towards reducing the confusion that applicants now encounter during the process.

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New Jersey Spend Down

TITLE 10. HUMAN SERVICES
CHAPTER 71. MEDICAID ONLY
SUBCHAPTER 4. RESOURCES

N.J.A.C. 10:71-4.1 (2015)

§ 10:71-4.1 Financial eligibility standards; resources

(a) The resources criteria and eligibility standards of this section apply to all applicants and beneficiaries.

(b) Resources defined: For the purpose of this program a resource shall be defined as any real or personal property which is owned by the applicant (or by those persons whose resources are deemed available to him or her, as described in N.J.A.C. 10:71-4.6) and which could be converted to cash to be used for his or her support and maintenance. Both liquid and nonliquid resources shall be considered in the determination of eligibility, unless such resources are specifically excluded under the provisions of N.J.A.C. 10:71-4.4(b).

(c) Availability of resources: In order to be considered in the determination of eligibility, a resource must be "available." A resource shall be considered available to an individual when:

1. The person has the right, authority or power to liquidate real or personal property or his or her share of it;

2. Resources have been deemed available to the applicant (see N.J.A.C. 10:71-4.6 regarding deeming of resources); or

3. Resources arising from a third-party claim or action are considered available from the date of receipt by the applicant/beneficiaries, his or her legal representative or other individual acting on his or her legal behalf in accordance with the following definition and provisions.

i. Definition of "availability of resources in third-party situations": In third-party situations in which applicants/beneficiaries have brought an action or made a claim against a third party who is or may be liable for payment of medical expenses related to the cause of the action or claim, funds are considered available or countable at the moment of receipt by the applicant/beneficiary, his or her legal representative, guardian, relative or any person acting on the applicant's/beneficiary's behalf. Such funds should be considered available or countable at the earliest date of receipt by any of the aforementioned entities.
(1) In determining resource eligibility in accordance with N.J.A.C. 10:71-4.5(a), those funds actually available to the applicant/beneficiary or any person acting on his or her behalf as of the first day of the month subsequent to the month of receipt shall be considered a countable resource, unless otherwise excluded (see N.J.A.C. 10:71-4.4).

(2) If a bona fide lien or judgment exists against such funds, making all or some portion of the funds inaccessible to the applicant/beneficiary, CWAs shall deduct the encumbrances and consider the remaining amount as a countable resource.

(3) If between the date of receipt of such moneys and the first day of the subsequent month the applicant/beneficiary pays outstanding medical expenses and/or other expenses, the CWA shall consider only the funds remaining after such payment as a countable resource.
……..

(e) Resource eligibility: Resource eligibility is determined as of the first moment of the first day of each month. If an individual or couple is resource ineligible as of the first moment of the first day of the month, subsequent changes within that month in the amount of countable resources will not affect the original determination of ineligibility. If resource eligibility is established as of the first moment of the first day of the month, resource eligibility is established for the entire month regardless of any increase in the amount of countable resources.

1. This policy applies equally to individuals and couples in the month of application. Regardless of the date of application, resource eligibility is determined as of the first moment of the first day of that month.

2. If, prior to the first moment of the first day of the month, the applicant or beneficiary has drawn a check (or equivalent instrument) on a checking or similar account, the amount of such check shall reduce the value of the account. The value of such accounts shall not be reduced by any unpaid obligations for which funds have not already been committed by the drafting of a check.

i. When checks have been drawn on an account, the CWA shall review the appropriate account registers or check stubs to ascertain the actual balance as of the first moment of the first day of the month. Full documentation of such circumstances is required.

(f) No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes.

1. In order for the cash reward to continue to be excluded, the funds shall be separately identifiable (that is, not commingled with other funds or assets), but held in a separate account. Any increase in the value of the excluded cash reward shall also be excluded.

TITLE 10. HUMAN SERVICES
CHAPTER 71. MEDICAID ONLY
SUBCHAPTER 4. RESOURCES

N.J.A.C. 10:71-4.5 (2015)

§ 10:71-4.5 Resource eligibility standards

(a) For eligibility in the Medicaid Only Program, total countable resources are subject to the following limits. (See N.J.A.C. 10:71-4.1(b) regarding definition of resources, N.J.A.C. 10:71-4.2 regarding countable resources, and N.J.A.C. 10:71-4.8 regarding resources of a couple when one member is applying for Medicaid for institutional services.)

1. Resource eligibility is determined as of the first moment of the first day of the month. Changes in the amount of countable resources subsequent to the first moment of the first day of the month shall not affect eligibility.

2. In the case of checking accounts, the balance as of the first moment of the first day of the month shall be reduced by the amount of any checks which have been drawn on the account but which have not yet cleared the financial institution.

(b) Resource maximum for a couple: Participation in the program shall be denied or terminated if the total value of a couple's countable resources exceeds $ 3,000.

1. Definition of a couple: A couple shall be defined as a man and a woman who are legally married, or who have been determined to be a couple by the Social Security Administration for receipt of RSDI benefits, or who are living together in the same household and presenting themselves to the community in which they live as husband and wife.

(c) Resource maximum for an individual: participation in the program shall be denied or terminated if the total value of an individual's resources exceeds $ 2,000.

(d) Resource maximum (institutionalized individuals): The resource maximum for an individual in (c) above applies equally to individuals institutionalized in a Title XIX approved facility. Countable resources held in the institution (for example, trust funds, personal needs accounts) together with those held outside the institution, are to be applied toward the resource maximum. If the resource maximum is exceeded, Medicaid eligibility will cease. (See also N.J.A.C. 10:71-4.8 regarding resource eligibility for institutionalized individuals.)

(e) The grandfather clause: An individual who satisfied the following criteria may have his/her resource eligibility determined in accordance with procedures formerly used in New Jersey's OAA, AB, and DA programs if it is more advantageous to the individual (see Financial Assistance Manual, Chapter 300, for regulations in effect prior to January 1, 1974):

1. The individual was participating in the Medicaid program during December 1973 under one of New Jersey's Federal programs for the aged, blind, or disabled;

2. The individual has, since December 1973, continuously resided in New Jersey;

3. The individual has, since December 31, 1973, continuously been an eligible individual, an eligible spouse, or an essential person participating in the Medicaid program.

i. Essential person status (refers to spouse only): A spouse who received Medicaid coverage in December 1973 because of his/her status as a person "essential" to the existence of an eligible person is also considered eligible for receipt of Medicaid Only benefits under the provision of the grandfather clause. Such spouse must continue to reside with the eligible individual alone in order to retain his/her essential person status.

ii. Once an individual's essential person status is terminated, he/she must again apply for benefits and be determined eligible or ineligible on the basis of criteria used for other newly applying aged, blind, or disabled individuals.

(f) No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes.

1. In order for the cash reward to continue to be excluded, the funds shall be separately identifiable (that is, not commingled with other funds or assets), but held in a separate account. Any increase in the value of the excluded cash reward shall also be excluded.

New York Spend Down

18 CRR-NY 368.4NY-CRR

OFFICIAL COMPILATION OF CODES, RULES AND REGULATIONS OF THE STATE OF NEW YORK
TITLE 18. DEPARTMENT OF SOCIAL SERVICES
CHAPTER II. REGULATIONS OF THE DEPARTMENT OF SOCIAL SERVICES
SUBCHAPTER B. PUBLIC ASSISTANCE
ARTICLE 2. DETERMINATION OF ELIGIBILITY—CATEGORICAL
PART 368. AID TO THE AGED, BLIND OR DISABLED

18 CRR-NY 368.4
18 CRR-NY 368.4

368.4 Financial factors.

(a) Financial need.
The need for public assistance of all persons who are aged, blind or disabled shall be determined in accordance with department regulations.

(b) Exploration of income and resources.
All income and resources shall be indicated on the application form and evaluated as to their immediate and/or potential availability to remove or reduce need for assistance and utilized for such purpose in accordance with applicable regulations of the department. When a clear, consistent statement of financial need and resources cannot be obtained, a full field investigation by the validation staff shall be made.

(1) Residents of private institution. Residents of private institution.
When an applicant is a resident of a private non- profit institution, such as a home for the aged or blind, or a home for adults, determination shall be made as to: the basis upon which he was admitted, particularly whether the home is obligated to provide care and maintenance by the terms of a contract, by the provisions of the charter of the home, or by conditions and restrictions on gifts and bequests made to the home: resources possessed at admission or acquired during residence and their disposition; and provision of special medical care and burial.

(i) A resident is not eligible for assistance if and so long as the home is obligated to provide for all his needs and the home is able to fulfill its obligation. If it is determined that the home is unable to fulfill its obligation to the resident, this obligation may, with the approval of the department, be considered to be suspended while the home's inability continues. In such instances, as well as in instances where the home's obligation has terminated, as when a contract has been fully performed by the home or has been terminated by agreement of the parties, determination of eligibility shall be made as for any other applicant. This shall include determination as to whether or not resources assigned, donated or contributed to the home have been exhausted for the maintenance of the applicant prior to his application for public assistance.

(ii) For the applicant resident in a home on the basis of a non-life care contract, resources deposited with the institution shall be investigated to determine to what extent they have been used to meet the cost of his care and to provide burial reserve. Until the resources exclusive of burial reserve have been exhausted on this basis, there is no eligibility for public assistance while the applicant is a resident of the home, except when his contract with the home is considered suspended. If the applicant had such an arrangement but has left the institution, there shall be a determination as to any unused resources and their availability to him.
(2) Admission to an institution. Admission to an institution.
A social services official shall include in the exploration and evaluation of resources the availability and suitability of care in a private home for the aged or a private institution for adults for which an applicant may be eligible because of membership in a fraternal organization or other association or in a government home or institution for which an applicant may be eligible because of veteran status. Since admission to such a home or institution is voluntary, this resource is not to be considered available if the individual is unwilling to use such facilities.

18 CRR-NY 368

Connecticut Spend Down

CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
UNIFORM POLICY MANUAL

Date: 7-1-98 **Transmittal: UP-98-31** **4005.15**

Section:
Treatment of Assets

Type:
POLICY

Chapter:
Asset Limits

Program: **AFDC**
AABD
MA
FS

Subject:
Reduction of Excess Assets

4005.15 A. Applicants

1. AFDC, AABD Residents of Rated and Non-Rated Housing, FS

At the time of application, the assistance unit is ineligible for assistance until the first day it reduces its equity in counted assets to within the particular program asset limit.

2. MA, AABD Residents of Long Term Care Facilities

At the time of application, the assistance unit is ineligible until the first day of the month in which it reduces its equity in counted assets to within the asset limit.

B. Recipients

1. AFDC and AABD Residents of Rated and Non-Rated Housing

a. If the assistance unit acquires an asset during a month and thereby exceeds the asset limit, eligibility is not affected if the unit properly reduces its equity in counted assets to an allowable level by the end of the month.

b. If the assistance unit does not reduce its excess assets to an allowable level by the end of the month the excess first occurs, the unit is ineligible for assistance for that month, and remains ineligible until the date it properly reduces it assets to an allowable level.

2. MA and AABD Residents of Long Term Care Facilities

a. If the assistance unit acquires an asset during a month and thereby exceeds the asset limit, eligibility is not affected during the month the excess first occurs.

4005.15 B. 2. Recipients (continued)

b. If the assistance unit does not reduce its excess assets to an allowable level by the end of the month the excess first occurs, the unit is ineligible as of the first day of the following month and remains ineligible until the first day of the month in which the unit properly reduces its assets to an allowable level.

3. FS

a. If the assistance unit acquires an asset during a month and thereby exceeds the asset limit, eligibility is not affected if the unit properly reduces its equity in counted assets to an allowable level prior to the date of the unit's first scheduled payment following the expiration of the advance notice period (cross reference: 1570, Fair Hearings).

b. If the assistance unit has not reduced its excess assets to allowable level by the unit's first scheduled payment following the expiration of the advance notice period, the unit is ineligible for such allotment, and continues to be ineligible for assistance until the date it properly reduces its excess assets to allowable level.

C. Fair Market Value

When reducing excess assets, the assistance unit must receive fair market value for the expended assets unless it can demonstrate to the Department's satisfaction that the assets were not transferred for the purpose of qualifying for assistance (cross reference: Section 3025, Transfer of Assets).

Date: 7-1-98	**Transmittal: UP-98-31**	**P-4005.10**
Section: **Treatment of Assets**		**Type:** **PROCEDURES**
Chapter: **Asset Limits**	**Program:**	**AFDC** **AABD** **MA**
Subject: **Determining the Earliest Date of Eligibility - Applications**		**FS**

P-4005.10 AFDC, AABD Residents of Rated and Non-Rated Housing, FS

1. If the assistance unit has excess assets, do not grant assistance to be effective prior to the date the unit properly reduces its assets to an amount equal to or less than the appropriate asset limit.

2. If the assistance unit does not properly reduce its assets during the application period, deny the application because of excess assets.

MA, AABD Residents of Long Term Care Facilities

1. If the assistance unit has excess assets, do not grant assistance to be effective prior to the first day of the month in which the unit properly reduces its asset to an amount equal to or less than the appropriate asset limit.

2. If the assistance unit does not properly reduce its assets during the application period, deny the application because of excess assets.

Pennsylvania Spend Down

58 Pa. Code § 178.1. General policy on MA resources common to all categories of MA.

(a) An applicant/recipient is resource eligible for MA if his total resources considered in determining resource eligibility do not exceed the MA resource limit in Appendix A for the appropriate MA Program. Revisions to the MA Resource limits will be published as a notice in the*Pennsylvania Bulletin*, recommended for codification in the *Pennsylvania Code*. The MA resource limits are based on the following:

(1) For aged, blind or disabled persons requesting NMP-MA, 42 CFR 435.721 (relating to general requirements) requires that the SSI resource limit at 20 CFR 416.1205 (relating to limitation on resources) be used.

(2) For children and their parents requesting NMP-MA, 42 CFR 435.711 (relating to general requirements) requires that the state's AFDC resource limit at 45 CFR 233.20(a)(3)(i)(B) (relating to need and amount of assistance) be used.

(3) For individuals requesting NMP-MA who do not fall under the Federal categories, the GA resource limits at section 432.5 of the Public Welfare Code (62 P. S. § 432.5) are used.

(4) For persons requesting MNO-MA, 42 CFR 435.840 and 435.841 (relating to medically needy resource standards: General requirements; and medically needy resource standards: Reasonableness) require a reasonable standard approved by the Health Care Financing Administration.

(b) Resources are counted in determining resource eligibility for MA, unless specifically excluded in this chapter.

(c) An applicant/recipient is ineligible for MA on the date that his resources exceed the MA resource limit in Appendix A for the appropriate MA Program and he remains resource ineligible until his resources are equal to, or less than, the resource limit. The disposition of excess resources shall meet the fair consideration provisions for the appropriate program.

(d) Resources are considered at their equity value unless specified otherwise. The equity value of nonexcluded real property which is legally available to the applicant/recipient is a resource.

(e) A person receiving AFDC, GA, SBP or SSI and who is living in the household of a person applying for, or receiving, MA is not included in the determination of MA eligibility.

(f) Resources which are not excluded shall be reviewed to determine if they are actually available. Only those resources which are actually available are considered resources when determining MA eligibility.

(g) An applicant/recipient shall take reasonable steps to obtain and make available resources to which he is, or may be, entitled unless he can show good cause for not doing so.

(h) The reimbursement provisions of the cash assistance programs do not apply to MA.

(i) If an applicant/recipient converts or sells a resource, whether excluded or nonexcluded, the newly acquired cash or item is a resource and is subject to the appropriate resource criteria for continuing eligibility.

(j) Resources used by the applicant to pay for medical expenses during the retroactive eligibility period or the continuing eligibility period are not counted once the resources are used to pay the medical expenses.

Pennsylvania Department of Public Welfare – OIM Policy Manual

340.12 Reducing Excess Resources

At application, if the individual's resources are over the limit, the CAO will advise the individual that a decision on eligibility can be postponed if he or she plans to spend the excess resources. The CAO will not count resources used to pay for medical expenses or an irrevocable burial. Eligibility is decided on for the retroactive period and for continuing MA as if the resources never existed. If resources are spent for anything other than medical expenses, the eligibility date is the day after the resources are reduced to the limit. 55 Pa. Code § 178.1(j)

For retroactive eligibility, the amount of resources counted should be the amount of resources owned as of the first day of the medical services for which the individual tries to get MA.

NOTE: To become eligible for retroactive MA, a individual can borrow money to pay a portion of any unpaid medical expenses for which he or she is responsible.

Example: Mr. Smith's hospital bill for December is $5,647. At that time, he had excess resources of $450, which he spent on new furniture after he was released from the hospital. Mr. Smith borrows $450 and pays a portion of the hospital bill with the money. Mr. Smith is resource eligible, because he used the borrowed money to pay unpaid medical expenses, thereby lowering his excess resources to zero.

The CAO will make an eligibility decision within 30 days. The decision may be made within 45 days if the CAO tells the individual about the delay in writing. If the individual lowers resources after eligibility is denied, he or she must fill out a new application.

If the resources of a recipient are over the limit, the CAO will send the individual an advance notice telling the individual that he or she is ineligible. If the individual proves that resources are reduced within ten days of the notice, eligibility will be continued. There is no overpayment.

Any time the individual has or receives resources that, when added to other countable resources, puts the individual over the resource limit for the MA **category**, he or she is ineligible for MA unless the resources are reduced.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 03 OMM/ADM – 1

TO: Commissioners of Social Services

DIVISION: Office of Medicaid Management

DATE: January 29, 2003

SUBJECT: Elimination of Conditional Eligibility and Changes in the Treatment of a Homestead

SUGGESTED DISTRIBUTION:	Medicaid Staff Temporary Assistance Staff Fair Hearing Staff Legal Staff Third Party Resources Staff Staff Development Coordinators
CONTACT PERSON:	Local District Liaison Upstate: (518) 474-8216 NYC: (212) 268-6855
ATTACHMENTS:	Homestead Chart: Resource Status and Placement of Lien for Institutionalized SSI-Related Medicaid A/Rs (available on-line)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
02 OMM/ADM-3		360-1.4(f)	SSL 367-f		GIS 96 MA/036
97 ADM-13		360-1.4(k)	SSL 369		GIS 93 MA/024
96 ADM-8		360-4.7(a)	SSA 1917		
92 ADM-53		360-7.11(a)	42 CFR		
91 ADM-17			435.845		
90 ADM-40			PHL 415.3		
90 ADM-36			(h)(1)(i)(b)		
89 ADM-47					
89 ADM-45					
93 INF-32					

I. PURPOSE

This Administrative Directive (ADM) advises social services districts of the elimination of the option to authorize Medicaid pending the liquidation of excess non-liquid resources and changes in the treatment of a homestead.

II. BACKGROUND

A. Conditional Eligibility

Previously, 18 NYCRR 360-4.4(e) provided social services districts with the option to authorize Medicaid for an applicant/recipient (A/R) pending liquidation of excess non-liquid resources (conditional eligibility). Social Services districts generally utilized this option when the homestead of an institutionalized person was no longer exempt as a resource.

However, Federal regulations at 42 CFR 435.845 (b) provide that, in determining the amount of an individual's resources for Medicaid eligibility, "States must count amounts of resources that otherwise would not be counted under the conditional eligibility provisions of the SSI or AFDC programs."

B. Homestead Exemption

Previously, 18 NYCRR 360-4.7(a)(1) provided that a homestead lost its exempt status if the owner was in a medical facility in permanent absence status as defined in Section 360-1.4(k), and no spouse, child under 21 years of age, certified blind or certified disabled child, or other dependent relative was living in the home.

As stated in GIS 93 MA/024, the adverse court decision in Anna W. v. Bane requires the State to conform to the policy used by the Supplemental Security Income (SSI) program regarding the exemption of the homestead of an SSI-related Medicaid A/R. Under the SSI program, the homestead is not a countable resource as long as the A/R, having left the home, indicates intent to return home (regardless of the individual's actual ability to return home).

State regulations have been revised to eliminate the option to provide conditional eligibility pending liquidation of excess non-liquid resources, and to continue to exempt the homestead of an SSI-related Medicaid A/R where there is an expressed intent to return home.

III. PROGRAM IMPLICATIONS

A. Elimination of Conditional Eligibility

1. Excess Resources

Unless incurred medical expenses reduce excess resources at or below the allowable resource standard, Medicaid cannot be authorized for any case with excess resources. (See 91 ADM-17 "Treatment of Medical Assistance Applications When There are Excess Resources and Outstanding Medical Bills" for excess resource spenddown policies and procedures.)

2. Available Resources

All resources owned by a Medicaid A/R are considered to be available unless there is a legal impediment that precludes liquidation. If there is a legal impediment to the disposal of a resource, the resource is not counted in determining resource eligibility until the legal impediment no longer exists. (See page 9.)

3. Mortgages

Mortgage agreements are assumed to be negotiable unless the A/R presents convincing evidence of a legal impediment to transferring ownership.

If there is no legal impediment to transferring the mortgage, the value of the mortgage is an available resource. The debtor's payments against the principal are considered the conversion of part of this resource, and thus are not counted as income in determining eligibility. The debtor's payments of interest are counted as unearned income. The value of the mortgage is the outstanding principal balance, unless the A/R documents that the current market value of the mortgage is less by submitting an evaluation from someone regularly engaged in the business of making such evaluations, such as a bank or other financial institution, licensed private investor or real estate broker.

If there is a legal impediment to transferring the mortgage, the value of the mortgage is not counted as an available resource. However, the debtor's payments of both principal and interest are counted as unearned income.

If a mortgage is sold by the A/R for less than fair market value, the sale should be reviewed as a potential prohibited transfer.

1. Intent to Return to the Homestead

Regulation 18 NYCRR 360-1.4(f) currently reads as follows: "Homestead means the primary residence occupied by a medical assistance applicant/recipient and/or members of his/her family. Family members may include the applicant's/recipient's spouse, minor children, certified blind or certified disabled children, and other dependent relatives. The homestead includes the home, land and integral parts such as garages and outbuildings. The homestead may be a condominium, cooperative apartment or mobile home. Vacation homes, summer homes or cabins are not considered to be homesteads."

Regulation 18 NYCRR 360-4.7(a)(1) has been revised to provide that even if the homestead is not occupied by a family member listed above, the homestead remains exempt as long as the SSI-related Medicaid A/R, having left the homestead, expresses an intent to return home. Medical evidence is no longer relevant in determining the exempt status of a homestead.

The expression of intent to return home only affects the exempt status of a homestead. "Intent to return" has no impact on chronic care budgeting. An individual in a nursing facility is presumed to be permanently absent unless adequate medical evidence shows that the individual is expected to return home. (See 89 ADM-47 "Treatment of Income and Resources for Institutionalized Spouses/Individuals and Legally Responsible Relatives.")

The expression of intent to return home has no impact on the requirement to impose a lien. Social services districts are reminded that they must impose a lien on the real property of an institutionalized individual who is not reasonably expected to return home, unless the real property is the homestead and is occupied by a spouse, minor or certified blind or certified disabled child, or a sibling with equity interest who has lived in the home for one year prior to the A/R's admission to a medical facility. If adequate medical evidence documents that an individual is reasonably expected to return home, no lien can be imposed. If the individual is discharged from the medical institution and returns home, the lien must be removed. (See 02 OMM/ADM-3, "Medicaid Liens and Recoveries.")

2. Certain Relative(s) Resides in the Homestead

If an SSI-related Medicaid A/R has no intent to return, the homestead remains an exempt resource as long as a spouse, minor or certified blind or certified disabled child, or dependent relative continues to reside in the home. Dependent

relative means any of the following relatives of the A/R, provided that over 50 percent of the maintenance needs of the relative are met by the A/R: a child, stepchild, grandchild; parent, stepparent, grandparent; aunt, uncle, niece, nephew; brother, sister, stepbrother, stepsister, half-brother, half-sister; cousin; or in-law.

3. Opportunity to Transfer

The homestead is a countable resource when an SSI-related Medicaid A/R has no intent to return home and the home is not occupied by a relative described in 2. above. When the homestead of an institutionalized A/R is a countable resource, the social services district must provide the institutionalized A/R with an opportunity to transfer the home to a:

- sibling with equity interest who lived in the home for at least one year prior to the A/R's admission to a medical facility

- adult child who resided in the home for at least two years immediately before the date the individual became institutionalized, and provided care which permitted the individual to reside at home rather than in an institution or facility.

C. Life Estate Interest

For the purpose of determining countable resources, a life estate is not considered to be an available resource. Therefore, the value of a life estate does not impact resource eligibility, and no lien may be imposed on a life estate. However, transfer policies apply to a life estate. (See 96 ADM-8, "OBRA '93 Provisions on Transfers and Trusts," for detailed instructions regarding life estates.)

D. Calculation of Excess Resources

The equity value of real property (the fair market value less any legal encumbrances) is added to any other countable resources to determine the amount of excess resources.

The applicant is responsible for providing acceptable documentation of the fair market value of the property. In order to find the applicant eligible for Medicaid (or eligible subject to spending down a specified amount of excess resources), the social services district must have: an appraisal; the listed asking price accompanied by a market analysis or appraisal, if any; or, if neither is available, a full value tax assessment. However, if it is clear, based on the approximate value of the property, that the

applicant is ineligible due to excess resources, the district can rely on a statement from the applicant as to the property's value in order to make that determination.

When the property is sold, the net proceeds of the sale are counted as a resource. The costs associated with the sale of such an asset (e.g., advertising costs, commissions, closing costs, taxes, attorney's fees, repairs in connection with the sale of the property, etc.) will be offset against the proceeds of the sale.

IV. REQUIRED ACTION

A. Elimination of Conditional Eligibility

As stated in GIS 96 MA/036, for Medicaid cases active or pending on or after October 9, 1996, social services districts cannot authorize conditional eligibility for A/Rs pending liquidation of excess non-liquid resources, beginning with the December 1, 1996 budget.

Note: Medicaid must continue to be provided to a recipient who is receiving conditional Supplemental Security Income (SSI) benefits, under an agreement with the Social Security Administration to dispose of resources that exceed the SSI dollar limits on resources.

1. New Cases

   Conditional eligibility cannot be authorized for Medicaid applications pending on or after October 9, 1996.

2. Undercare Cases

   Any undercare case active on or after October 9, 1996 which was authorized for Medicaid pending the liquidation of excess non-liquid resources must be reviewed for continued resource eligibility at the next client contact, but no later than at recertification.

   At the time of this resource review, the social services district must determine the current equity value of the non-liquid resource. The district must subtract the amount that the recipient will have to repay to the district, pursuant to the assignment of proceeds, for the period beginning with the Medicaid authorization and ending at the time of the review. If after this calculation the recipient continues to have excess resources, the social services district must provide adequate and timely notice and discontinue the case.

   In addition, social services districts are reminded to provide for recovery of the amount expended by Medicaid from the date of authorization through the date of the discontinuance. In the event that a recipient requests a fair hearing with aid

continuing, if the district is upheld, the district may also seek to recover Medicaid paid on behalf of the recipient during the aid continuing period.

3. Reapplications

If an otherwise eligible individual who was denied Medicaid due to excess resources incurs medical bills that are at least equal to the amount of excess resources, Medicaid will be authorized for the individual beginning with the third month prior to reapplication, or the month in which the excess resources are spent down, whichever is later.

In some cases, although an individual will incur medical bills equal to the amount of the excess non-liquid resources that was calculated based on the appraisal, the actual net proceeds from the liquidation of the property will be less than the incurred medical bills. If the difference between the amount of excess resources that was calculated based on the appraisal and the amount of net proceeds is not the result of a prohibited transfer, districts must use the remaining outstanding viable medical bills to reduce the individual's excess income or Net Available Monthly Income (NAMI), beginning with the first month of Medicaid authorization.

B. Homestead Exemption

1. Intent to Return Home

Effective October 22, 1993, as long as an SSI-related Medicaid A/R expresses an intent to return home, the social services district must exempt the homestead as a countable resource. A written statement or documentation in the case record by the eligibility worker verifying that the individual stated his or her intent to the worker is sufficient documentation.

If the A/R is unable to state the intent to return home at the time of application, a past statement of intent is sufficient. If the A/R is able to state the intent to return home, a current statement is necessary.

If the A/R is incapable of stating his or her intent, and no past statement of intent exists, the A/R's authorized representative, power of attorney, health care proxy, or guardian may state the A/R's intent to return home. Authorized representative means the individual the applicant designates to represent him or her in the application process. Health care proxy means the individual the applicant legally authorizes to make decisions regarding medical treatment if the applicant becomes temporarily or permanently incapable of communicating his or her own care or treatment wishes.

2. Continued Intent to Return Home

The A/R's intent to return home must be verified and documented at each recertification, except that the last documented statement of intent will be sufficient in situations where the A/R is no longer capable of stating his or her intent.

3. Non-Homestead Property

Social services districts must not apply the intent to return policy to property that did not meet the definition of a homestead prior to the time the individual left the property. For example, the intent to return policy does not apply if the individual did not consider the property to be his or her primary residence at the time the individual left the property, or the individual never resided in the property.

4. Homestead Occupied by Certain Relatives

Even if an individual does not intend to return to the homestead, the social services district must exempt the homestead as long as a spouse, minor or certified blind or certified disabled child, or dependent relative continues to live there.

5. Opportunity to Transfer

When the homestead of an institutionalized A/R is a countable resource, the social services district must provide the institutionalized A/R with an opportunity to transfer the home to a:

- sibling with equity interest who lived in the home for at least one year prior to the A/R's admission to a medical facility

- adult child who resided in the home for at least two years immediately before the date the individual became institutionalized, and provided care which permitted the individual to reside at home rather than in an institution or facility.

If the institutionalized individual elects to transfer the home, the social services district must document the intent to transfer and allow a reasonable timeframe to accomplish the transfer (90 days, or longer if necessary due to difficulty or delay beyond the control of the institutionalized individual).

6. No Home Maintenance Deduction

There is no deduction from a permanently institutionalized individual's income for home maintenance expenses.

7. Non-SSI-Related Medicaid A/Rs

There is no change in the treatment of a homestead for medically needy ADC-related A/Rs. A homestead that is essential and appropriate to the needs of the household is exempt as a resource. A homestead that is essential and appropriate to the needs of the household is also exempt for individuals in the Family Health Plus, Low Income Families (LIF) and Single Individuals/Childless Couples (S/CC) categories.

8. SSI-Related Homestead Chart

The attachment to this ADM is a chart that details the treatment of a homestead for SSI-related institutionalized individuals. It indicates the effects of "intent to return" and certain relatives residing in the home on the resource status of a homestead and whether a lien would be imposed.

C. Life Estates

Social services districts must follow the life estate policy set forth in 96 ADM-8.

D. Calculating Excess Resources

1. Verification of Equity Value

The A/R is responsible for providing an appraisal or the listed asking price of non-liquid resources. The equity value (fair market value less any legal encumbrances) is added to any other countable resources to determine the amount of excess resources.

2. Incurred Medical Bills

If incurred medical bills do not at least equal the amount of excess resources, the individual is not eligible for Medicaid.

If an otherwise eligible A/R has incurred medical bills which equal or exceed the amount of excess resources, the non-liquid property does not have to be sold before Medicaid can be authorized.

For an otherwise eligible A/R, once incurred medical bills are at least equal to the amount of excess resources, Medicaid can be authorized for up to three months prior to the month of application or reapplication, or beginning with the month in which the excess resources are spent down, whichever is later. The excess income amount or NAMI will be reduced to account for older outstanding medical bills that Medicaid cannot cover, and which are not offset by any amount of excess resources. Applicants who are denied due to excess resources must be advised to reapply when medical bills are anticipated to equal or exceed the amount of excess resources.

3. Liquidation Costs

Once non-liquid property is sold, the selling price less any costs associated with the sale (e.g., advertising costs, commissions, closing costs, taxes, attorney's fees and repairs in connection with the sale of the property) is a countable resource.

4. Legal Impediment

All non-exempt resources are considered available and applied against the appropriate resource standard, unless there is a legal impediment that precludes the liquidation of the resource. A legal impediment exists when an A/R is legally prohibited from, or lacks the authority to, liquidate the asset. For example, a legal impediment exists when an A/R needs the consent of a co-owner of a jointly owned asset in order to sell the asset, and the co-owner refuses to give consent. If such consent is given, the asset is considered an available resource beginning with the month following the month of consent. However, if the co-owner agrees to purchase the A/R's share of the property, the asset is considered an available resource. (For rules governing treatment of jointly owned assets, refer to 96 ADM-8, "OBRA '93 Provisions on Transfers and Trusts.")

Please note that even when a legal impediment precludes the liquidation of a permanently institutionalized individual's interest in non-exempt real property, a lien must be imposed on the A/R's interest in the property. However, no lien may be imposed on non-exempt real property if the property is the institutionalized individual's former primary residence, and is occupied by a sibling with equity interest who has resided in the home for at least one year prior to the A/R's admission to a medical facility.

In instances where a guardianship petition has been filed, the resources of the A/R are not considered available until a guardian has been appointed, or the guardianship proceeding has been otherwise resolved. Once the guardian is appointed,

the resources of the A/R are considered available, and may result in ineligibility until incurred medical bills exceed the amount of excess resources, or until the resources are reduced at or below the allowable resource standard.

5. Mortgage

The A/R is responsible for providing documentation of the current market value of a negotiable mortgage. Documentation can be obtained from anyone regularly engaged in the business of making such evaluations (e.g., banks or other financial institutions, licensed private investors or real estate brokers). The estimate must show the name, title, and address of the source.

V. NOTICE REQUIREMENTS

The "Informational Notice to Institutionalized Individuals with Real Property" (Attachment I of 02 OMM/ADM-3,"Medicaid Liens and Recoveries") and the LDSS-4466 (Rev. 12/06/01), "Notice of Intent to Impose a Lien on Real Property (Institutionalized Individual)," (Attachment II of 02
OMM/ADM-3, "Medicaid Liens and Recoveries") have been revised to conform to the policy outlined in this ADM.

Social services districts must provide the revised informational notice to all persons requesting such information, and must include the notice with all applications involving an institutionalized person.

Social services districts must provide the LDSS-4466 (Rev. 12/06/01), "Notice of Intent to Impose a Lien on Real Property (Institutionalized Individual)," to the institutionalized individual and retain a file copy whenever a lien is imposed on real property. The case record should document the date a notice was given to the Medicaid recipient.

The informational notice must be reproduced by the social services district until such time as the notice becomes available. This notice may be reproduced on county letterhead. Any other modifications to the notice must be submitted to the following address in accordance with instructions contained in 97 ADM-13, "Procedure for Requesting Approval of Local Equivalent Forms":

Christina
Larsen
New York State Department of
Health Office of Medicaid
Management ESP, Corning Tower,
Room 2029
Albany, NY
1223

OTHER ELIGIBILITY

REQUIREMENTS OWNERSHIP

AND AVAILABILITY

Generally, no grant or loan to an undergraduate student for educational purposes is considered an available resource. There are some variations on this policy according to the category of the A/R. (See **INCOME** LIF DISREGARDS, ADC-RELATED DISREGARDS, SSI-RELATED DISREGARDS and S/CC DISREGARDS)

When an SSI-related A/R has a guardian, trustee, representative payee or other person/institution responsible for managing his/her funds, the local district reviews the terms of the trust or other agreements/documents to assure that the SSI-related A/R's resources are actually available for his/her care. If a trust was created from the A/R's funds, and, if the trustee has any discretion to expend any of the trust income for the benefit of the A/R, then all of the trust principal which could be expended in any way to benefit the A/R is considered available. In instances where the client has a formal fiduciary and the fiduciary is uncooperative, the local district commences a recovery proceeding under SSL 104.

If an A/R is alleged to be incapable of managing his/her own finances and there is no one with the legal authority to make decisions concerning the A/R's income/resources, the A/R's income and resources, as appropriate, are considered unavailable from the time a petition to appoint a guardian is filed until the court appoints a guardian. The income and resources, as appropriate, are considered unavailable to the A/R prospectively and for a retroactive period of three months.

Where there is a question of availability, the local social services district documents why the resource is not considered available and any actions taken to secure the resource for the SSI-related A/R.

If an SSI-related A/R jointly owns a home, but s/he is out of the home due to an informal separation and the spouse in the home refuses to sell, the A/R's share is an unavailable resource.

Verify Status: (a) When the A/R indicates that s/he has a joint financial institution account;

(b) When the A/R indicates joint ownership of assets;

(c) When the A/R indicates that an LRR has available assets;

OTHER ELIGIBILITY

REQUIREMENTS <u>OWNERSHIP</u>

<u>AND AVAILABILITY</u>

(d) When a child in the household has assets in his/her own

name; (e) When someone other than the A/R pays the mortgage.

Documentation: Sufficient to establish an audit trail:

Copies of financial institution account statements from the bank, mortgagor or insurer, or statements of availability from the LRR.

All efforts to obtain unavailable income and/or resources, as appropriate, are documented in the case record.

New Jersey – Evidence

TITLE 1. ADMINISTRATIVE LAW
CHAPTER 10B. DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES APPLICANT/RECIPIENT HEARINGS
SUBCHAPTER 10. DISCOVERY

N.J.A.C. 1:10B-10.1 Discovery

(a) The county welfare agency or the Division of Medical Assistance and Health Services shall provide the applicant/recipient or his or her authorized representative an opportunity to review the entire case file and all documents and records to be used in the hearing. The review shall occur at a reasonable time before the hearing as well as during the hearing.

(b) If a party wants information other than what is provided in (a) above, the party must request permission from the judge. The judge may permit the additional discovery only if there is good cause. The judge may not delay the hearing to allow for additional discovery.

Pennsylvania – Evidence

55 Pa. Code § 275.1 Policy

§ 275.1. Policy.

(a) Right to appeal and have a fair hearing. The policy with regard to the right to appeal and have a fair hearing will be as follows:

(1) The freedom of the applicant or recipient to request a hearing is a fundamental right and is not to be limited or interfered with in any way.

(2) The regulations contained in this chapter, in accordance with the law, afford every person applying for or receiving a money payment, medical assistance, food stamps or services the right to appeal from a Departmental action or failure to act and to have a hearing if he is dissatisfied with a decision refusing or discontinuing assistance in whole or in part.

(3) As used in this chapter, the term departmental includes, in addition to County Assistance Offices, agencies which administer or provide social services under contractual arrangements with the Department.

(4) The term assistance as used in this chapter means a money payment, medical assistance, food stamps and services.

(i) Right of appeal. Therefore, the opportunity for a hearing will include the right of appeal from the following:

(A) A denial, suspension or discontinuance in whole or in part.

……

55 Pa. Code § 275.3. Requirements

(a) Rights of the appellant. An appellant has the right to appear in person at the hearing and he may represent himself, or he may be represented. For food stamps, the appellant may also bring friends or relatives to the hearing; however the hearing examiner may limit the number of persons in attendance at the hearing if space limitations exist. The appellant or his representative, if any, have the following rights:

(1) To present evidence on his own behalf, to bring witnesses or documents he deems necessary, and to confront and cross-examine witnesses the county office, administering agency or social service provider will produce to support its decision or action.

(2) To request a subpoena from the hearing officer for the production of evidence or witnesses that he feels will be essential in obtaining necessary facts.

(3) To examine prior to the hearing, as well as during the hearing, documents which the county office, administering agency or social service provider will introduce as evidence in the hearing as well as the contents of the case files as provided for in § 105.5 (relating to access by an individual to his case file) or appropriate confidentiality regulations for the service program.

(i) If the appellant requests material from the case file, other than narrative material dated prior to January 1, 1980 which the County Assistance Office, administering agency, or service provider believes is within one of the exceptions of § 105.5(b) or appropriate confidentiality regulations for the service program, a hearing officer will determine prior to the date of the hearing, whether the material is relevant and whether it tends to support the position of the appellant. However, under no circumstances may the same hearing officer conduct the hearing.

(ii) The hearing officer will refuse access to irrelevant material, but will allow access with appropriate safeguards to relevant, confidential information which supports the position of the appellant. If the office, agency, or provider wishes to protect the confidentiality of such relevant information, in spite of the decision of the hearing officer, it must provide the relief requested. The case record material will be made available on as early a date as possible prior to the hearing so that the appellant and his representative shall have ample opportunity to review the evidence of the county or that of the administering agency or social service provider and prepare their case.

(iii) To obtain a hearing officer's determination of whether the appellant may examine the material in question, the County Assistance Office, administering agency or social service provider will promptly provide the Office of Hearings and Appeals a summary of the situation which will include the following:

(A) The decision or action which precipitated the appeal and the reasons for it.

(B) The specific document or subject matter the appellant wants to examine.

(C) The reasons for withholding the material.

(iv) A copy of the summary will also be promptly provided to the appellant, who shall have the right, on a timely basis, to submit to the hearing officer the reasons for requesting the specific matter which the appellant wishes to examine. The Hearing Officer will notify the County Assistance Office, administering agency or social service provider of his determination as to what materials are required to be disclosed with a copy sent to the appellant and his representative, if any. The determination will be made on a timely basis in advance of the date of the hearing. No administrative appeal will be permitted from the determination of the hearing officer.

(4) To be provided with the names of the County Assistance Office, administering agency or social service provider staff members and witnesses who will be present at the hearing.

(5) To request reconsideration of the reversal of a hearing decision by the Secretary within 15 days from the date of reversal.

(6) To appeal the final administrative action of the Department within 30 days from the date of its order.

(b) Time limitations on right to appeal. An applicant or recipient must exercise his right of appeal within the following time limits. Appeals which do not meet the following time limitations will be dismissed without a hearing:

(1) Thirty days from the date of written notice of a decision or action by a County Assistance Office, administering agency or service provider except for food stamps which time limits are indicated in paragraph (4).

(2) Sixty days from the date of a decision or action by a County Assistance Office, administering agency or service provider when they did not send written notice because the notice was not required or 60 days from their failure to act except for food stamps which time limits are indicated in paragraph (4).

(3) When the county office, administering agency or service provider fails to send written notice which was required of the action and of the right of appeal or because of administrative error, ongoing delay or failure to take corrective action that should have been taken, the time limit in paragraphs (2) or (4) will not apply. For a period of 6 months from the date of the action or failure to act, the client shall have the right of appeal and shall exercise that right in writing. After 6 months from the date of the county office, administering agency or service provider action or failure to act, a written appeal may be filed with the agency provided that the client signs an affidavit stating the following:

(i) The client did not know of his right of appeal or believed the problem was being resolved administratively.

(ii) The client actually believes the county office erred in its actions.

(iii) The appeal is being made in good faith. Appeals which do not meet the time limitations and requirements set forth in this paragraph and in paragraphs (1) and (2) will be dismissed without a hearing.

(iv) An appeal request received by the agency prior to March 1, 1979 will be controlled by the regulation in effect at the time the request was received by the agency.

(4) For food stamps, the time limits in paragraphs (1) and (2) will not apply. A household may request a hearing within 90 days from the date of an action by the

County Assistance Office or loss of benefits. Action by the County Assistance Office shall include a denial of a request for restoration of benefits lost more than 90 days but less than 1 year prior to the request. Additionally, a household may request a hearing to dispute its current level of benefits at any time within a certification period.