TO: Commissioners of Social Services

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

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DSS-329EL (Rev. 9/89)
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 prepays 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.
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 copayment 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 copayment 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.
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.