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¦ ADMINISTRATIVE DIRECTIVE ¦

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TRANSMITTAL: 96 ADM-15

DIVISION: Health & Long Term Care

TO: Commissioners of Social Services

DATE: August 13, 1996

SUBJECT: Excess Income Program Clarifications/Prepayment of Client Liability (Pay-In) Program

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SUGGESTED DISTRIBUTION:	Medical Assistance Staff Staff Development Coordinators Accounting Supervisors
CONTACT PERSON:	1-800-343-8859 Medical Assistance: Upstate - Ann Hughes, ext. 3-5501 New York City - 212-383-2512 Fiscal: Bureau of Local Financial Operations, Regions 1 through 4 - Roland Levie, ext. 4-7549 Region 5 - Marvin Gold, 212-383-1733
ATTACHMENTS:	Available On-Line: Attachment I - Excess Income Case Examples Attachment II - Excess Income Desk Aid Attachment III - Optional Pay-In Program For Individuals With Excess Income Attachment IV - Pay-In Case Examples Attachment V - Required Format For Pay-In Plans Attachment VI - Mandatory Pay-In Notices

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
96 ADM-12 91 ADM-11 87 INF-19 87 ADM-4		360-4.8(c)	366(2)(b); Chapter 81 of the Laws of 1995; SSA 1903(f) 42CFR 435.831 435.914	MARG pp 223-231	GIS 95 MA/025 95 LCM-131

I. PURPOSE

This Administrative Directive (ADM):

- clarifies the treatment of the retroactive eligibility period and the use of medical expenses when determining countable income for purposes of eligibility for Medical Assistance (MA); and

- informs social services districts of required action as a result of the enactment of Chapter 81 of the Laws of 1995, which established a statewide program for prepayment of the client liability under the Excess Income program.

II. BACKGROUND

Federal regulation 42 CFR 435.831 provides that, in determining an individual's eligibility for Medical Assistance (MA), if countable income exceeds the income standard, the State must deduct from income medical expenses that are not subject to payment by a third party. Once deduction of medical expenses reduces excess income to the income standard, the individual is eligible for MA.

A. Retroactive Eligibility Period and Use of Medical Expenses

42 CFR 435.831 formerly provided that states must use a prospective period of not more than six months to compute income. Thus, when determining eligibility for the three month retroactive period, it was always considered a discrete period.

87 ADM-4 set forth guidelines for use by social services districts in applying medical expenses toward an excess income liability. This ADM provided that paid expenses in excess of an individual's monthly liability could be used to obtain additional months of appropriate coverage for up to six months at a time. Unpaid expenses in excess of the individual's liability and not payable by the MA program could also be used to obtain additional months of coverage, as long as the expense remained viable and had not previously been used to obtain eligibility.

Effective March 14, 1994, the Health Care Financing Administration amended 42 CFR 435.831 to provide states the option to include in the period over which income is computed all or part of the three-month retroactive period. The amendment also clarified the appropriate use of paid and unpaid medical expenses to reduce income to the income standard, requiring changes in the Department's excess income policy.

B. Mandatory Pay-In Program

The Omnibus Budget Reconciliation Act of 1990 amended 42 U.S.C. 1396b(f) to allow, at state option, the prepayment of an individual's income liability to the state agency. Formerly, Section 366(2)(b) of the Social Services Law (SSL) authorized social services districts with Department-approved prepayment plans to permit an otherwise eligible individual whose income exceeded the income standard to become eligible for MA by paying his/her income liability directly to the social services district. Five social services districts operated approved Pay-In programs under this provision.

Chapter 81 of the Laws of 1995 amended SSL Section 366(2)(b) to require all social services districts to offer excess income recipients the option to participate in the Pay-In program.

III. PROGRAM IMPLICATIONS

A. Retroactive Eligibility Period and Use of Medical Expenses

The change in federal regulations allows income to be computed over a period of not more than six months, which may include all or part of the three-month retroactive eligibility period. The retroactive period begins no earlier than the first month in the period in which the individual received covered services and, when combined with prospective months, can be no longer than six months. In some circumstances, combining all or part of the retroactive period with prospective months of eligibility may be more beneficial to the individual.

In determining medical expenses to be deducted from countable income during a period, social services districts must include all paid or unpaid medical expenses incurred during such period, to the extent that the expenses have not been deducted previously in establishing eligibility. As explained more fully in Section IV.A.2.b. of this ADM, paid expenses in excess of a client's liability generally are not carried forward from one period to the next. Viable unpaid expenses may be carried forward from a previous period when the individual's eligibility was established in such previous period without deducting all such incurred, unpaid expenses. However, viable unpaid expenses are no longer carried forward from a period in which a spenddown liability was not met.

B. Mandatory Pay-In Program

Allowing individuals with excess income to obtain MA eligibility by prepaying their excess income liability to the social services district has several advantages:

- improves access to medical care for recipients by helping to ensure timely authorization of MA eligibility;

- o provides recipients with a simplified procedure for achieving and maintaining eligibility;
- o reduces processing time currently associated with excess income cases;
- o reduces program costs by permitting purchase of necessary care and services at MA rates, rather than private pay rates; and
- o eliminates inappropriate program costs due to inadvertent or fraudulent provider billing of medical expenses which have been used to establish eligibility.

Social services districts must operate a Pay-In program in accordance with a plan approved by this Department. Only those plans meeting the requirements outlined in Section IV.B. of this ADM will be approved. Upon approval of the district's Pay-In plan, the district must offer all excess income recipients the option of participating in the Pay-In program on a voluntary basis.

Administrative expenses associated with social services districts' operation of a Pay-In program may be exempt from the State share cap on administrative costs, pursuant to an approved local plan submitted in accordance with 96 ADM-12.

IV. REQUIRED ACTION

Department regulation 360-4.8(c) and 87 ADM-4 detail requirements for the use of paid or incurred expenses for necessary medical or remedial care, not subject to payment by a third party, to reduce excess income. This includes medical expenses paid for or incurred by public programs of the State or any of its political subdivisions, in accordance with 91 ADM-11. Once incurred medical expenses reduce income to the MA income standard, the individual is eligible for MA; however, no MA payment will be made for those incurred medical expenses used to establish eligibility.

A. Income Periods and Use of Medical Expenses

1. Accounting Periods

In determining an individual's eligibility, districts must use a period of not more than six months to compute income (an accounting period). More than one accounting period may be used. Federal regulations continue to allow districts to treat the entire retroactive period as one three-month period, or divide the retroactive period into monthly periods. In addition, the amendment to 42 CFR 435.831 now allows districts to add all or part of the retroactive period to the first prospective months, for a combined period not to exceed six months.

2. Determining Deductible Expenses

a. Required Deductions

In determining medical expenses to be deducted from income, federal regulations provide that the following must be included:

(i) expenses incurred for Medicare and other health insurance premiums, deductibles or other coinsurance charges;

(ii) expenses incurred for necessary medical and remedial services that are recognized under State law but are not covered by MA; and

(iii) expenses incurred for necessary medical and remedial services that are covered under the MA program.

(Under the provisions of 18 NYCRR 360-4.8(c) these expenses must be deducted in the order listed above.)

b. When Expenses Are Used

(i) Paid Expenses

A paid expense must be deducted from income in the accounting period in which it is paid. This means that a paid expense in excess of the individual's liability cannot be used to provide more than six months of coverage (the maximum period over which income can be computed). In addition, once a six month liability is met, and full coverage provided, any subsequent expenses paid by the recipient during such period are not carried forward to the next excess income period.

An exception is made for expenses incurred and paid in the three-month retroactive period. When no part of the retroactive period is included in the first prospective accounting period, expenses incurred and paid during the retroactive period which have not been used previously to establish eligibility can be deducted from income in the first prospective accounting period.

(ii) Unpaid Expenses

An unpaid expense must be deducted from income in the accounting period in which it is incurred. In addition, if the individual's liability is met in that period without deducting all incurred, unpaid expenses, the excess unpaid expenses for services not covered by the MA program may be carried forward and

deducted from income in a subsequent accounting period.

Unpaid expenses from the retroactive and pre-retroactive accounting periods may be carried forward and deducted from income as long as they remain viable and have not previously been used to establish eligibility.

In both these situations (excess unpaid expenses incurred in a prior accounting period, and unpaid, unused, retroactive or pre-retroactive expenses), the requirement to carry such expenses forward ends when the individual has an excess income liability that is not met, or the individual no longer has an excess income liability. This is a change from previous excess income policy, which allowed the balance of unpaid expenses which were not used to establish eligibility to be carried forward as long as the expense was viable.

ATTACHMENT I of this ADM provides case examples to clarify these requirements. ATTACHMENT II was developed as a Desk Aid to outline excess income policy.

B. Mandatory Pay-In Program

Social services districts are required to offer individuals with excess income the opportunity to reduce their excess income by pre-paying to the district the amount by which their income exceeds the MA income standard. In establishing a Pay-In program, districts must follow the guidelines provided in Department regulation 360-4.8(c)(4) and outlined in this section.

1. Pay-In Program Requirements

a. Client Option

Participation in the Pay-In program is optional on the part of the recipient. Currently, A/Rs must be provided with the DSS-4038, "Explanation of the Excess Income Program," whenever an excess income liability is determined. In addition, upon approval of a district's Pay-In plan, the district must provide ATTACHMENT III (or an approved local equivalent form) to these individuals, which explains the pay-in option. The individual's election of the pay-in option must be documented in writing and retained in the case record.

It is recommended that districts screen potential Pay-In participants to ensure sufficient medical expenses each month to warrant their participation. Individuals who pay their excess income to the district and then do not receive MA covered services cannot receive refunds until sufficient time has elapsed to establish that no claims have been

submitted. Individuals without sufficient medical expenses to meet their excess income liability should not be encouraged to participate.

b. Pay-In Accounts

The district must establish a special account to safeguard the amounts paid to the district by the individuals. Such amounts must not be retained in interest-bearing accounts.

c. Pay-In Periods

The individual may elect to pay-in for periods of one to six months. When the pay-in period is longer than one month, the individual may pay the full excess income amount at the beginning of the period, or may pay in monthly installments.

For pay-in periods of less than six months, full coverage will not be authorized; instead, outpatient coverage (MA Coverage Code 02) will be authorized. Please note, however, that outpatient coverage will be authorized for a particular month only after the excess income liability has been met for that month. When the individual pays the full excess income liability for a six month period, full coverage (MA Coverage Code 01) will be authorized for that period.

d. Combining Paid/Incurred Medical Expenses With Pay-In Amounts

(i) In order to obtain coverage, the participant must pay to the social services district the amount by which his or her net available income exceeds the MA income standard for the appropriate period. In determining this amount, the district must deduct from income any necessary medical expenses incurred during the period which are not payable by the MA program. (See ATTACHMENT IV, Example 1.)

(ii) If the individual has paid his/her liability to the district and subsequently incurs expenses during the covered period for services not covered by the MA program, the district must either refund to the recipient the amount of the medical expense from the recipient's account, or may credit the amount to the recipient's account in a subsequent excess income period. (See ATTACHMENT IV, Example 2.)

NOTE: Once the individual has paid in the amount of his/her excess income to the social services district, he/she is treated like any other MA recipient. Thus, the recipient must receive services from MA providers in order for MA payment to be made. Credit or refunds will not be provided for covered services rendered to the recipient by nonparticipating providers.

e. Reconciliation of Pay-In Accounts

Districts must periodically reconcile the amount in the MA recipient's account with the amount of MA payments made on the recipient's behalf. The amount in the account, minus any amount to be refunded pursuant to paragraph d.(ii) above, must be compared to the MA payments made for services provided during the covered period. Any unused pay-in amounts must be refunded to the recipient or credited to a subsequent excess income period. (See ATTACHMENT IV, Example 3.)

NOTE: When reconciling the individual's Pay-In account, social services districts must take into consideration any off-line payments made on behalf of a participant, since these payments will not be reflected in the Adjudicated Claims history report.

2. Requirements for District Plans

Chapter 81 of the Laws of 1995 requires that social services districts submit to the Department no later than February 1, 1996, a plan for the operation of a Pay-In program. The plan must include a detailed description of how the district will administer the program, enroll recipients, safeguard monies in recipient accounts, reconcile accounts with payments made to MA providers, and refund or credit recipients for overpayments. ATTACHMENT V contains the required format for submitting this plan. This format was provided to social services districts in Local Commissioners Memorandum 95 LCM-131, dated December 6, 1995.

Plans must be submitted to:

New York State Department of Social Services
Division of Health and Long Term Care
40 North Pearl Street
Albany, NY 12243

The Department must approve, disapprove, or request modification of a social services district's Pay-In plan, within 90 days of receipt of the plan. The Department has reviewed the plans of those districts currently operating approved Pay-In programs, and has advised such districts of any necessary modifications.

3. Notice Requirements

New client notices have been developed to accommodate the requirements of the Pay-In program. These notices are included as attachments to this ADM.

To inform recipients of refunds or credits to their Pay-In accounts due to medical expenses not covered by the MA program, use "Notice of Credit Due to Uncovered Expenses," ATTACHMENT VI(a), or "Notice of Refund Due to Uncovered Expenses," ATTACHMENT VI(b).

To inform recipients of the results of reconciliation of their accounts with the MA claims paid on their behalf, use "Notice of Credit Due to Review of Medical Assistance Claims," ATTACHMENT VI(c), or "Notice of Refund Due to Review of Medical Assistance Claims," ATTACHMENT VI(d).

These notices must be manually reproduced until they become available as Department forms.

In addition, social services districts may elect to discontinue recipients who fail to pay-in for three or more consecutive months. For districts which exercise this option, discontinuance language has been programmed in to the Client Notices Subsystem (CNS) as follows:

> This is because you elected to pay your excess income to this agency in order to receive Medical Assistance coverage. You have not paid your excess income to this agency for three or more consecutive months. Also, you have not submitted paid or unpaid medical bills that are equal to or more than the amount your income is over the income limit.
>
> If you incur medical bills in the amount of your excess income in the future, you may reapply.

This language will be generated by using reason code E22.

4. Claiming Refunds

Money received by the district should be deposited into the TA-53 Social Services trust and agency account. For CAMS districts using the Cash Receipt subsystem these payments may be entered into Cash Receipts with a Revenue Reason Code of 403 (TA-53). All other districts must perform the Cash Receipt posting function manually. No monies would be reported to the State at the time the payment is received from the client.

As noted previously, districts must periodically (at least yearly) reconcile the balance in the MA recipient's TA-53 account with the amount of MA payments made on the recipient's behalf. A refund of the TA-53 balance to the recipient or account credit toward subsequent periods is necessary if the recipient has paid in more than the amount of MA claims paid out by the local district.

If the recipient receives services from MA providers for a particular period then either all or part of the pay-in amount (depending on the amount of MA services received) should be applied to the cost of the MA service. When this happens, for CAMS districts the payments should be transferred out of the TA-53 account and into the A-1801 Repayment of Medical Assistance account by a CR modification. These instructions apply to

CAMS districts with Cash Receipts functions. For more information, please refer to Chapter 2, Cash Receipts, of the Cash Management Procerdural Manual. All other districts should manually perform this function. The payments should be displayed on the refund roll as Medical Assistance pay in.

The MA pay-in amount received and applied to MA expenditures must be claimed as a refund on the Schedule E (Computation of Federal and State Aid on Medical Assistance, DSS-157) in the month in which the payment is applied to the MA expenditure. The refunds should be reported in columns 2 and 7 (FP Other) on line 27 (Other) of the Schedule E.

If the refunds are related to enhanced funding categories such as Native Americans, Mental Hygiene Releasees or Refugees/Entrants, then the refunds should be carried forward to either the RF-3 (Adjustment Claim for Additional State Aid on Expenditures 100% Reimbursable) or the RF-6 (Monthly Claim for Reimbursement and Statistical Report Assistance to Resettled Refugees). Please review the Fiscal Reference Manual, Volume 2, Chapter 3 for Schedule E, RF-3, and RF-6 claiming instructions.

If the reconciliation determines a balance is due to the client a check should be produced for the balance. Upon receipt of a manually prepared DSS-3209, or worker and supervisor signed local district authorization form, Accounting should initiate a check from the client's TA-53 account. In lieu of payment, the client account may be credited for subsequent excess income periods.

5. Administrative Expenses

The local social services districts will claim the costs of administering this program as F-4 functional expenditures on the Schedule D-4, Calculation of Medical Assistance Eligibility Determination/Authorization/Payments Cost Shares-DSS-2347-B2. Instructions for completing the Schedule D-4 are found in Chapter Eleven of the Local Cost Allocation Manual - Bulletin 143b.

As stated in Section III, Program Implications, administrative expenses associated with the Pay-In program are exempt from the State share cap on administrative costs. To receive this exemption, social services districts must submit a plan for exemption to the Bureau of Local Financial Operations for approval, in accordance with 96 ADM-12.

V. SYSTEMS IMPLICATIONS

The Pay-In/Excess Income Subsystem, which provides the mechanism for district tracking of pay-in amounts and paid/incurred bills used by participants to obtain eligibility, became available for local district use on May 6, 1996. Training on the Subsystem was provided to all local districts during April and May, 1996.

Districts electing to have this Department conduct an annual reconciliation of Pay-In participants' paid claims with pay-in amounts must make the appropriate entries in the Subsystem. The first scheduled reconciliation for Pay-In program participants with entries in the Subsystem is scheduled for early spring, 1997.

VI. EFFECTIVE DATE

This Directive is effective August 1, 1996. Chapter 81 of the Laws of 1995 required social services districts to submit a plan for operating a Pay-In program to the Department no later than February 1, 1996.

Martin J. Conroy
Acting Deputy Commissioner
Division of Health and Long Term Care

EXCESS INCOME EXAMPLES

1. Combining Retroactive Period With First Prospective Period

Mrs. Spencer, age 67, applies for MA in May and is determined to have monthly excess income of $160 and a six month excess of $960. She presents the following bills:

February - $900 inpatient hospital bill (paid)
May - $150 physician's bill (unpaid)

She anticipates ongoing medical expenses for a chronic condition.

(a) In this example, if the retroactive period were treated as a distinct period, Mrs. Spencer would not be eligible in the retroactive period because her hospital bill did not equal or exceed her six month liability and there were no other covered services received in the period. Because the bill was paid, and was not in excess of her liability, it cannot be deducted from income in a subsequent accounting period. Therefore, she is also not eligible for outpatient coverage in May, because her medical expenses do not equal or exceed her monthly liability for that month. Mrs. Spencer may or may not be eligible in subsequent months, depending on the amount of medical expenses she incurs.

However, if the retroactive period were combined with the first prospective period, the paid inpatient bill can be combined with the May physician's bill of $150. Mrs. Spencer has now met her six month liability. She can be given full coverage for February through July. Thus, the balance of the physician's bill not used to establish eligibility ($90) is payable by MA, up to the MA rate, and any additional covered expenses incurred by Mrs. Spencer in May, June or July are payable by MA.

(b) Assume Mrs. Spencer's February hospital bill was unpaid when she applied in May and the physician bill was paid. She would still not be eligible in the retroactive period, because the bill did not meet her liability. However, because this is a viable, unpaid medical expense that has not been used to establish eligibility, it can be carried forward and deducted from income in a subsequent accounting period. In this situation, it is more advantageous to Mrs. Spencer to treat the retroactive period as a distinct period.

In May, the agency uses the paid physician's bill of $150 and the unpaid hospital bill of $900 to meet the six month excess income liability. Any additional covered expenses incurred by Mrs. Spencer from May through October are also payable by MA.

2. Using Paid Bills To Establish Eligibility

Ms. Stuart is in receipt of Social Security Disability Benefits. Her monthly excess income is $27 and her six month excess is $162. She routinely submits expenses to meet her liability each month and is given outpatient coverage. In June, she goes to the chiropractor and incurs a $193 bill which she pays from her savings. The agency uses the paid bill in June to meet Ms. Stuart's six month liability of $162 and provides full coverage from June through November. Although there is a balance left on the paid bill of $31, it may not be used to establish eligibility in any additional months, since a paid bill must only be deducted from income in the accounting period in which it is paid.

3. Using Unpaid Expenses To Establish Eligibility

Mr. O'Hare files a new application for MA in January, 1997 on behalf of himself, his wife and their fourteen year old son. Mr. O'Hare is in receipt of UIB and meets the categorical requirements for ADC-U eligibility. The family is determined to have monthly excess income of $69, and a six month excess of $414. He presents the following bills:

September, 1996 - $250 dental bill (unpaid)
October, 1996 - $59 emergency room (paid)
- $60 x-ray (unpaid)
November, 1996 - $100 physician's bill (unpaid)
December, 1996 - $15 pharmacy bill (unpaid)
January, 1997 - $75 dental bill (unpaid)

In determining eligibility for October, the first month of the retroactive period, the agency uses the $59 paid expense and $10 of the viable, unpaid September bill to meet the October income liability. The balance of the September bill ($240) is used to establish eligibility for outpatient coverage in November, December and January, allowing the unpaid expenses from those months to be paid by MA. The balance of $33 from the September bill, which was not used to establish eligibility, is credited toward the income liability in February. If the O'Hare's incur medical expenses equal to $36 in February ($69 minus $33) they may be given outpatient coverage in February. If they do not incur expenses sufficient to meet the February income liability, the $33 credit is not available in any subsequent months.

However, if Mr. O'Hare were to pay the $250 dental bill in a subsequent accounting period, any amounts not previously used to establish eligibility would be deducted from income as a current payment. In the example above, $33 could be deducted from income in the period in which the payment was made.

OPTIONAL PAY-IN PROGRAM FOR INDIVIDUALS WITH EXCESS INCOME

Individuals whose income exceeds the Medical Assistance income limit may still receive help with medical bills. The form DSS-4038, "EXPLANATION OF THE EXCESS INCOME PROGRAM" explains that if you bring in or send us your medical bills each month which are equal to or more than the amount of your excess income, you may receive coverage for any other medical expenses you incur from a Medical Assistance provider in that month. Explained below is another way you can get Medical Assistance coverage.

Instead of bringing or mailing in your medical bills each month, you can pay to this agency the amount of your income that is over the limit. If you decide to pay this money to us, you will be given outpatient coverage for the month you are paying for, and will not have to wait until you incur a medical bill. If you pay a total of six months of excess income, you will be given outpatient and inpatient coverage for that six month period. Once you are given coverage, you can use your Medical Assistance card to obtain services from your doctor or other medical provider. You must be sure the provider accepts payments from the Medical Assistance program before you receive the service.

If you pay your excess income to this agency, and then get or pay a bill for medical services that Medical Assistance does not cover (for example, chiropractor's service), we will give you a refund or we will give you a credit toward the next available uncovered month. You must bring in or send to us the paid or unpaid bill in order to get a credit or refund.

* Remember, we will not pay for or give credit for any bill or portion of a bill that is covered by Medicare or other health insurance that you have.

If you decide to pay your excess income to the agency, from time to time we will review the amount of all the claims we have paid for you, and compare this amount to the amount you have paid. If you have paid more than you should have, we will decide to give you a refund or give you credit for coverage in another month. We will make this decision based on your circumstances.

You should consider the following before deciding to take part in the PAY-IN PROGRAM.

1. Unless you know that you will need medical services during a month, it is not to your benefit to pay us your excess income that month.

2. If you pay your excess income for a period and then do not use your Medical Assistance card, it may take at least a year for us to give you a refund or credit. This is because we must wait to see if any claims have been paid for you for that period.

3. If you decide you want to pay your excess income to this agency, you may do so every month, or only in those months that you know you will need medical services. If you want, you may pay us for more than one month at a time, up to six consecutive months. However, if you decide to pay your excess income and then do not make a payment to us for three consecutive months, you may receive a notice of our intent to close your case. You may reapply for Medical Assistance if you incur or expect to incur medical expenses at least equal to your excess income and wish to make a payment or submit bills to receive coverage.

YOUR MEDICAL ASSISTANCE EXAMINER CAN ANSWER ANY QUESTIONS YOU HAVE AND HELP YOU DECIDE IF PAY-IN IS RIGHT FOR YOU.

PAY-IN EXAMPLES

1. Mr. Kelly, age 65, applies for MA in August, 1996, and is determined to have $65 in excess monthly income. He has outstanding medical bills in June and July for which he is seeking coverage. Since he anticipates ongoing medical expenses, Mr. Kelly elects to participate in the Pay-In program. He has documented the following medical expenses:

   June: $19 prescriptions (paid)
   $50 chiropractor (unpaid)
   $85 physician (of which he has paid $50)

   July: $27 prescriptions (paid)
   $65 physician (unpaid)

   The bills Mr. Kelly paid in June (total $69) exceed his excess income liability and he is given outpatient coverage (Coverage Code 02) for June. His physician, who is a participating provider, is sent the DSS-3183, informing him that he may bill MA for the balance of the June bill, up to the Medicaid rate. Because Mr. Kelly paid $4.00 more than necessary, he can be given a credit to reduce his July excess income.

   In July, the $4 credit and the $27 paid prescription bill are deducted from Mr. Kelly's excess income liability, leaving a balance of $34. The unpaid chiropractor bill for services in June is still viable. Since this bill was not previously used to establish eligibility, $34 is applied toward the remaining liability to establish eligibility for outpatient coverage in July. Mr. Kelly should advise his physician that he is eligible for MA in July.

   Mr. Kelly has not yet incurred any expenses in August but has several medical appointments later in the month for which he would like coverage. His worker applies that portion of the June chiropractor bill which was not previously used to establish eligibility ($16) to reduce Mr. Kelly's excess income for August. Mr. Kelly pays $49 to the agency and is given outpatient coverage for the month of August.

2. Mr. Kelly pays $65 each month to the agency and is given outpatient coverage. In November, he returns to the chiropractor and incurs a bill for $45, which he submits to the agency. Because the district's policy is to give refunds in this situation, the worker follows appropriate procedures to issue a $45 refund to Mr. Kelly. (The district could also opt to give a credit toward the next excess income period. In this case, Mr. Kelly would be given a $45 credit in his Pay-In account for December and would only need to pay $20 to obtain coverage for that month.)

3. In January, 1998, the district performs a reconciliation of Mr. Kelly's pay-in account for the month of January, 1997. The district uses a report of MA claims paid for Mr. Kelly for services incurred during that month and finds that the total MA claims paid was only $50.00. Since Mr. Kelly paid $65.00 to the district that month, the district must either refund $15.00 to Mr. Kelly or give him a credit of $15.00 toward reducing excess income in a subsequent month.

NOTE: When a credit is provided to a recipient because of a non-covered expense incurred after the recipient has paid in for the period, and in the month of credit the individual does not obtain eligibility (i.e., he/she does not pay-in the balance of the liability or present bills equal to the balance), under excess income rules that credit is not available in any subsequent months. However, when a district is reconciling the amount a recipient has paid to the district with the amount of MA claims paid on the recipient's behalf, and the recipient has not received services equal to the amount paid, any credit is not lost with a break in eligibility. The district must continue to provide the credit until it is used or must issue a refund to the individual.

ATTACHMENT V
Pay-In Program Plan

I. Identifying Information:

A. District Name: _____
Address: _____
_____
_____

B. Contact Person: _____
Phone Number: _____

II. Organizational Units Involved in Pay-In Program:

A. Organizational unit with overall responsibility for the program:
_____

B. List other organizational units responsible for tasks associated with the program and specify the task (i.e., collection of payments; reconciliations; issuing refunds, etc.):

Unit Name	Task
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

III. Administration of the Pay-In program:

A. Obtaining Recipients' Voluntary Participation

1. Recipients are informed of the option to pay-in excess income to the District by:

_____ State Mandated Notice

_____ Local Equivalent Notice (A copy of the notice is attached to this plan)

2. Describe procedures for obtaining and documenting recipients' voluntary participation. Attach additional pages as needed.

2. Procedures for obtaining and documenting voluntary participation (continued):

B. Collection Procedures

1. Payments may be made by mail or in person, in the form of cash, checks or money orders. Describe the procedures for collecting and safeguarding recipients' payments, including procedures for dealing with checks returned for insufficient funds. (Note: Districts are not required to provide coverage until clearance of a check by the bank.) Attach additional pages as needed.

2. The District provides written instructions to recipients regarding where/how to make payments:

_____ Yes _____ No

If yes, a copy of these instructions is attached to this plan.

C. Tracking Paid/Incurred Medical Expenses

1.(a) The Department's automated process for tracking the recipient's payments and paid/incurred medical expenses will be used:

_____ Yes _____ No

If no, describe the process to be used. Attach additional pages as needed.

(b) An interim process is in place for tracking recipients' payments and paid/ incurred medical bills, in the event the Department system is not available at start-up of the program:

_____ payments and paid/incurred medical expenses are tracked manually, to be entered into Department system when available; or,

_____ describe the interim process to be used. Attach additional pages as needed.

2. Recipients who pay in to the District to obtain eligibility and subsequently incur expenses which are not covered by the MA program are treated as follows:

   _____ given a refund, up to the amount paid in

   _____ given credit toward their excess income liability in a subsequent budget period

   _____ on a case-by-case basis, given a refund or a credit as appropriate.

3. Recipients are informed of the decision to provide a refund or a credit and the amount thereof by:

   _____ State Mandated Notice

   _____ Local Equivalent Notice (A copy of the notice is attached to this plan)

D. MA Authorization Procedures

Describe the process for ensuring timely authorization of MA Coverage Code 02 (Outpatient) when monthly excess is met, or 01 (Full Coverage) if six month excess is met. Attach additional pages as needed.

E. Reconciliation of recipients' payments with MMIS adjudicated claims

1. Reconciliation of the recipient's prepayment account with MA claims paid on his/her behalf is conducted at least annually, at intervals of _____ months.

2. The Department's automated reconciliation process will be used to determine the amount of overpayment, if any:

_____ Yes _____ No

If no, describe the process to be used. Attach additional pages as needed.

3. Recipients who pay in to the District more than the amount of MA payments made on their behalf for the budgeting period are treated as follows:

   _____ refunded the difference between the total amount of MA claims paid and the amount paid-in to the District.

   _____ given credit toward their excess income liability in a subsequent budget period

   _____ on a case-by-case basis, given a refund or a credit as appropriate.

4. Recipients are informed of the decision to provide a refund or a credit and the amount thereof by:

   _____ State Mandated Notice

   _____ Local Equivalent Notice (A copy of the notice is attached to this plan)

F. Reporting of Pay-In amounts to the Department

Pay-In amounts, minus any refunds and/or credits are reported to the Department on Schedule E for purposes of distribution adjustment of federal, State, and local shares of Medicaid expenditures.

G. Other

Submit any additional information which will help in evaluating the plan, such as flow charts, or internal forms and reports.

Assurances/Signature

Pursuant to Chapter 81 of the Laws of 1995, _____ hereby submits this Plan for the operation of a Pay-In of Client Liability program, which allows eligible Medical Assistance (MA) recipients to reduce their excess income by pre-paying to the District the amount by which their income exceeds the MA income standard. We agree to administer the program in accordance with all applicable federal and State laws and regulations and provisions of this Plan.

We assure that we will:

(1) upon approval of the State Department of Social Services (SDSS), have in effect and operation a Pay-In of Client Liability Program which:

(i) meets the requirements of applicable federal and State law and regulations, and is designed to improve access to medical care for recipients and reduce program expenditures; and

(ii) provides all MA excess income recipients the option of participating in the program on a voluntary basis and allows election or rejection of the pay-in option on a monthly basis; and

(iii) allows a combination of paid/incurred expenses and pay-in amounts to be used to obtain eligibility; and

(iv) ensures that no MA funds are expended for the individual prior to the individual meeting his/her excess income liability; and

(v) allows the use and disbursement of pay-in amounts for services not covered under the State plan; and

(vi) ensures that amounts paid to the District by recipients are safeguarded in a separate non-interest bearing account; and

(vii) provides for at least annual reconciliation of the recipient's pay-in amounts with the amount of MA payments made on the recipient's behalf, and provides for a refund of unused pay-in amounts or a credit of the unused amounts in a subsequent excess income period.

Signature of Local Social Services Commissioner:_____
Date:_____