MANUAL MATERIAL TRANSMITTED					
MANUAL: Income Maintenance			**CHANGE NUMBER:** 28		
DELETE			**INSERT OR CHANGE**		
PAGES	**CHAPTER**	**DATED**	**PAGES**	**CHAPTER**	**DATED**
1	17	9/95	1 - 2	17	4/96
2	17	2/96	5 - 6	17	4/96
5 - 6	17	2/96	6 a	17	4/96
6 a	17	9/95	9	17	4/96
9 - 10	17	2/96	10	17	2/96
17 - 20	17	2/96	17 - 18 a	17	4/96
20 a	17	4/96	20 a - 20 b	17	4/96
20 b	17	2/96	21 - 24 a	17	4/96
21 - 23	17	2/96	47	17	9/95
24	17	9/95	48	17	4/96
47 - 48	17	9/95			
149 - 150	23	9/95	149	23	9/95
159	23	9/95	150	23	4/96
160	23	2/96	159	23	9/95
163	23	2/96	160	23	4/96
164	23	3/96	163	23	2/96
164 a	23	2/96	164	23	3/96
181	23	9/95	164 a	23	4/96
182	23	2/96	181 - 182	23	4/96
IM-NL-LTC-1	FORM	9/95	IM-NL-LTC-1	FORM	4/96
			IM-CSMA-1	FORM	4/96
DATE: March, 1996			**TO:** All Income Maintenance Manual Holders		

This change is being made to incorporate the LTC policy resulting from the Lemasters et al. v. Shalala et al. law suit.

On 9/1/95, WV DHHR implemented a new LTC policy. That 9/1/95 policy is now the subject of a lawsuit, Lemaster, et al. v. Shalala, et al. which was filed in federal district court in Charleston, West Virginia, on 2/8/96 against Donna Shalala, Secretary of HHS; Bruce Vladeck, HCFA Administrator and Gretchen

contribution are to be corrected using these instructions, only those affected by the suit.

POLICY STATEMENT: It is necessary to read the entire Manual change to understand the basic changes. The following policy statement is a guide only and not intended to be all-inclusive or to substitute for study of the Manual change.

There is still a 2-step process to determine eligibility and the amount of the client's contribution. The eligibility process continues to be the same. The client's spenddown amount is compared to the cost of his care. If the cost of care equals or exceeds his spenddown amount, the client is eligible for Medicaid. Once this eligibility determination is made, the spenddown amount is no longer considered in any way, i.e. it is not subtracted as a non-reimbursable medical expense in post-eligibility and is not added to the resource amount determined in post-eligibility to determine the client's total contribution toward his cost of care. Keep in mind that the process described here applies only to cases with a community spouse and a spenddown. The new LTC policy which went into effect on September 1, 1995 is still in effect for all other cases with a spenddown.

THE DEPARTMENT IS NOT, THEN, RETURNING TO THE POLICY IN EFFECT PRIOR TO SEPTEMBER 1, 1995, REGARDLESS OF ANY LETTERS THE CLIENT OR THE DEPARTMENT'S STAFF MAY HAVE RECEIVED FROM THE PLAINTIFFS' ATTORNEYS OR ANY OTHER ATTORNEY.

WORKER ACTION: For each affected case, the Worker must take the following actions:

- Complete a revised IM-LTC-1 (copy included in this change) for **each month** the client was required to contribute too much toward his cost of care. The first affected month cannot be prior to September 1, 1995. Complete the form using case record information and using the policy relating to cases with community spouses and spenddowns detailed in this change.

- Complete an IM-CSMA-1 for **each case.** This is a new, temporary form, and a copy is attached to this change.

NOTE: The revised IM-LTC-1 and the new IM-CSMA-1 have not been sent to print. Instead, please make copies to use until the issue is settled in court. If it appears that there will be a significant delay beyond June 1, 1996, we will have the forms printed and distributed. We expect to know early in May if the decision will be delayed much beyond June 1.

spenddown are plaintiffs in this action, any legal representatives of the plaintiffs are not permitted to contact any county, regional or state office staff with respect to the issue of the Lemaster lawsuit. If you are contacted by a legal representative of a plaintiff, please make a note of the contact and report it to the IM Policy Unit and inform the legal representative that, due to the suit, you cannot comment to them. Instruct them to contact counsel for WV DHHR. This does not prevent you from fielding questions from the institutionalized individual, his spouse, or family members with respect to that individual's case.

IM POLICY UNIT ACTION: The IM Policy Unit has the following responsibilities in these procedures.

- Review calculation sheets received from county offices to ensure that all necessary information is included and that the computations are correct. Any missing information will be requested by fax. All incorrect computations discovered will be faxed to the county for correction and confirmation to ensure that the Policy Unit's calculations are correct and/or based on correct information.

- Forward the necessary information to Finance to request issuance of a reimbursement check to the client. No reimbursements will be issued to the nursing facility. The focus of the suit is to protect income of the institutionalized spouse for the post-eligibility expenses. Therefore, some of the money the client already paid the facility belongs to the client. The reimbursement, then, represents the amount that the client should not have paid to the facility and which belongs to him and/or his spouse.

- Respond to inquiries from county Supervisors, CSM's or RD's about where individual clients are in the reimbursement process. Responses will be made by office automation except in emergency cases which will be handled by telephone or fax.

- Notify the county office as each case is processed by the Policy Unit and forwarded to Finance. Notices will be sent over office automation daily to those counties with cases processed. Once the case has been sent to Finance, no further inquiries are to be made unless 4 weeks has elapsed since the Policy Unit sent the case to Finance.

- Monitor total amounts expended due to the suit and prepare a final report.

Based on the deadlines contained in this instruction, Workers may inform those clients who inquire as to the approximate time of receipt of the reimbursement.

PURPOSE OF REIMBURSEMENT: As stated previously, the reimbursement amount is intended to reimburse the client for income he paid to the facility which should, according the the agreement, have been protected for the post-eligibility expenses. Therefore, the money belongs to the client. If he received an income deduction for a CSMA, that portion of the reimbursement is to be given to the community spouse. There is no requirement that any of the reimbursement be paid to the facility.

No part of the reimbursement amount is to be counted as income or as an asset to the institutionalized spouse, regardless of the length of time it may be retained.

Some clients have expressed the desire to keep extra money in an escrow or other account in case they will have to go back and pay the facility for the time during which this agreement between HCFA and the Department is in effect. ***They will not be required to back up and pay the facility or repay Medicaid for the time period covered by the HCFA agreement.***

Questions should be directed to the IM Policy Unit in the Office of Family Support.

17.1 INTRODUCTION

This Chapter describes the Department's policies and procedures for determining long-term care eligibility. Nursing care (long-term care) services are provided to eligible Medicaid individuals who reside in a nursing care or ICF/MR facility.

In addition to providing nursing care services to eligible Medicaid recipients, two coverage groups are eligible for alternative long-term care services by virtue of their need for nursing care and the availability of home-based or community-based nursing care services. These two coverage groups are part of the same Title XIX Waiver, even though they were begun at different times. The coverage group for elderly or disabled people is the HCB Waiver; the other is for mentally retarded or developmentally disabled individuals who live in facilities within their own communities and is the MR/DD Waiver.

This Chapter is organized the same way the entire Income Maintenance Manual is. Information in other sections of the Manual that also apply here are not repeated. Instead, reference is made to such information.

In determining eligibility for payment of nursing or alternative care, the Worker must ensure that the client, or his representative, is fully informed of the policies and procedures. This is necessary so that the client, his family or his representative is able to make informed decisions about the client's financial affairs.

However, the Worker must not, under any circumstances, suggest or require that the client, or representative, take any specific action in financial matters. The Worker must not act as a financial planner or make suggestions about the client's current or future financial situation. This includes comments about Estate Recovery. The Worker may respond to general questions about Estate Recovery, but must refer the client, or representative as found in Section 17.13,C.

The Worker must refer all inquiries about billing issues from the nursing or ICF/MR facility to the Long Term Care (LTC) Unit in BMS. The Worker must not contact BMS on behalf of the provider, but must refer the provider to BMS.

Questions from county staff about any aspect of long-term care cases must be directed to the IM Policy Unit in OFS, not to BMS.

- The Worker sends the ES-23 to the county office in which the representative lives. The following information is included on the ES-23:
  - The month the redetermination is due
  - The amounts and sources of the patient's income as shown in the case record
  - The amount of the client's resource and his total contribution
  - Type and amount of the client's assets
  - Amount of the CSMA and FMA
- The Worker who receives the ES-23 completes the interview with the representative and obtains required verification. He must explore all financial aspects of the case. See Sections 17.9 and 17.10.
- When the ES-2 is completed, the Worker in the county in which the representative lives records all pertinent information and returns the form to the originating county.
- The Worker in the originating county completes the redetermination. If the client is no longer eligible for Medicaid, the case is closed. If the client remains eligible for nursing care services, the data system is changed to reflect current circumstances and appropriate notification is sent.

2. Desk Redetermination

Form IM-LTC-3, LTC Desk Redetermination, is used to complete and transmit the redetermination.

The IM-LTC-3 is a checklist of items which are considered in completing the redetermination. Using information from the case record, the Worker reviews

17.3 CASE MAINTENANCE

A. COUNTY TRANSFER

See Chapter 2 for the appropriate coverage group. See Section 17.6 for notification requirements.

B. CHANGES AFFECTING INCOME AND POST-ELIGIBILITY CALCULATIONS

Changes which affect the client's income and/or post-eligibility calculations require reevaluation of both Medicaid eligibility and the client's contribution toward his cost of care.

Recipients of federal benefits such as RSDI, SSI, Black Lung or VA Benefits may receive periodic cost of living increases (COLA's). These changes are handled in accordance with instructions in Appendix B of Chapter 2.

C. DISCHARGES AND CLOSURES

1. Discharge Of An SSI Recipient

When an SSI recipient is discharged from a nursing facility, the Worker notifies SSA on form HS-3 of the date of discharge and the client's new address.

2. All Other Discharges

When a client is no longer in need of nursing level care and returns home or requires a lower level of care, eligibility for nursing care services ends after the notice period expires.

Upon discharge, the Worker must:

- Notify the LTC Unit.
- Take the appropriate data system action.
- Evaluate the client for all Medicaid coverage groups.

17.6 NOTIFICATION

The applicant or his representative must be notified in writing of the action taken on his application using form ES-NL-A. The recipient, his representative and the nursing facility administrator must be notified in writing in advance of any action that results in a change in the level of benefits using form ES-NL-B or ES-NL-C, whichever is appropriate. See Chapter 6. This Section discusses additional notification procedures related to nursing care cases.

A. WHO RECEIVES NOTIFICATION

Normally, notification is sent directly to the client. However, there are times when the Worker must determine who to notify as follows:

- When the client is not physically/mentally able to manage his own affairs, notification letters are addressed to the client's spouse or representative.

- When the client is not able to manage his own affairs and does not have anyone to act for him, notification letters are addressed to the facility administrator.

When the notification letters are addressed to someone other than the client, the following alterations in the form are required:

- In the upper left hand side, enter "re" followed by the client's name and case number.

- In the appropriate items, the name of the client (e.g., Mr. Smith or Mr. Smith's) is substituted for "you," "yours" or "client."

B. ES-NH-3, NOTICE OF CLIENT'S CONTRIBUTION TOWARD HIS COST OF CARE

The ES-NH-3 is used to notify the client or his representative, the nursing facility administrator and the LTC Unit of the client's contribution to his cost of care.

The form is completed when the eligible client first enters the nursing facility, leaves a nursing facility, is transferred to a different nursing facility, or when

4. SSI-Related Medicaid Test

If the client is not eligible under items 1, 2 or 3 above, his eligibility as an SSI-Related Medicaid client must be explored as another way to receive financial assistance for the cost of nursing care services.

All policies and procedures in effect for other SSI-Related cases apply to these cases, including the determination of a spenddown amount, if applicable.

EXCEPTIONS:

- Income is not deemed.
- The MNIL for one person is always used. See Chapter 10, Appendix A.
- The spenddown amount is determined on a monthly basis.
- Eligibility and the monthly spenddown, if any, are computed manually by the Worker. The M-219 system performs only post-eligibility calculations when Block 48 is greater than $0.

When the client's monthly cost of care equals or exceeds his monthly spenddown amount, the spenddown is assumed to be met and Medicaid eligibility is established. In addition, if his monthly spenddown amount exceeds his monthly cost of care, he may become eligible for Medicaid based on a 6-month POC, but not for payment of nursing care services.

Case examples of the entire process of determining eligibility and the amount of the client's contribution are found below in item D.

NOTE: Only for cases with a community spouse -- the amount of the spenddown is used only for comparison with the cost of care. It is not used as part of the client's contribution toward his cost of care as it is for all other M-219 system nursing care cases which must meet a spenddown.

NURSING CARE SERVICES

The determined amount must actually be paid to the community spouse for the deduction to be applied. If the client contributes less than the determined amount, only the amount actually contributed to the community spouse is deducted. If he has been ordered by a court or a Hearings Officer to contribute more to his spouse, the higher amount is deducted.

The following steps are used to determine the amount of the CSMA.

Step 1: Add together the actual shelter cost and the amount of the current Food Stamp SUA. See Chapter 10,

the individual, or in the case of a couple, either individual, is likely to return to the home within 6 months. The amount may be deducted for up to 6 months.

When both spouses are institutionalized, only one spouse may receive the OLE. They may choose which spouse receives the deduction.

e. Non-Reimbursable Medical Expenses

When the client is Medicaid eligible only as determined in items C,2, 3 or 4 above, incurred medical expenses, including nursing care costs (except for nursing care costs for clients with a community spouse), for which the client will not be reimbursed, are subtracted from his remaining income. The incurred, non-reimbursable medical expenses which may be deducted are the same as those which may be used to meet spenddown. See Chapter 10. When the client becomes eligible for nursing care services after expiration of a penalty period for transferring resources, any nursing care expenses incurred during the penalty period are deducted as non-reimbursable medical expenses.

All non-reimbursable medical expenses are totalled and any cents rounded up before entry in Block 71.

NOTE: For all cases except those with a community spouse, the amount of the client's spenddown, if any, which was calculated during the eligibility determination process, is treated as a non-reimbursable medical expense and subtracted from the client's income along with any other medical expenses the client may have. However, the spenddown amount is entered in Block 67, not in Block 71 with the other non-reimbursable medical expenses. Block 67 must equal 0 when there is a community spouse.

Step 2: Multiply the number of days the client was in Facility #1 by the per diem rate for the facility. The result is the clients cost of care for this facility for the month.

Step 3: Compare Step 1 to Step 2.

If Step 1 is less than or equal to Step 2, the client's entire contribution toward his cost of care is paid to Facility #1.

If Step 1 is greater than Step 2, the Step 2 amount is paid to Facility #1 and the difference between Step 1 and Step 2 is paid to Facility #2.

E. EXAMPLES

EXAMPLE: Single Individual With OLE, Categorically Eligible

A Pass-Through Medicaid recipient in the C-219 system enters a nursing home and wants Medicaid to pay toward his cost of care. He has $1,400/month unearned income. He is a single individual with OLE.

Medicaid eligibility is already established. Even though his income exceeds 300% of the SSI payment level, he is eligible without a spenddown as a Categorically Needy Medicaid recipient. Therefore, only post-eligibility calculations must be performed. To accomplish this, the C-219 system case is closed, and an M-219 system case is opened. The Worker records that the client was a Deemed SSI Recipient prior to nursing care eligibility so that eligibility may be restored if he no longer requires nursing care. Post-eligibility calculations are as follows:

$1,500	Client's gross monthly non-excluded income
- 30	Personal Needs Allowance
$1,470	Remainder
- 175	OLE
$1,295	Client's resource amount which is also his total contribution toward his cost of care.

NURSING CARE SERVICES

EXAMPLE: Single Individual Without OLE, Medically Needy

Same as above except the client has no OLE. The client's spenddown amount is the same as determined above.

	Post-Eligibility
$1,500	Income
- 30	Personal Needs Allowance
$1,470	Remainder
- 47	Medicare premium (non-reimbursable medical expense)
$1,423	Remainder
-1,280	Spenddown (non-reimbursable medical expense)
$ 143	Resource Amount

The client's total contribution toward his cost of care is:

$1,280	Spenddown
+ 143	Resource Amount
$1,423	Total Contribution

EXAMPLE: Married Individual Without Community Spouse, Medically Needy

Mr. Smith is married but has been separated from his wife for 10 years. He has 1 dependent child still living in his home. His monthly income is $1,411. He has non-reimbursable medical expenses of $43 (Medicare premium).

	Eligibility
$1,411	Income
- 20	SSI Disregard
$1,391	Remainder
- 200	MNIL
$1,191	Monthly Spenddown

NURSING CARE SERVICES

Post-Eligibility

Community Spouse Deduction:	$ 421	Shelter
	+ 207	SUA
	$ 628	Total Shelter/Utilities
	- 377	30% Min. CSMA
	$ 251	Excess Shelter/Utilities
	+1,254	Min. CSMA
	$1,505	
	- 640	Total gross monthly non-excluded income of Community Spouse
	$ 865	CSMA

Family Maintenance Deduction:	$1,254	Min. CSMA
	- 275	Income
	$ 979	Remainder ÷ 3 = $326 FMA

$1,705	Income
- 30	Personal Needs
$1,675	Remainder
- 865	CSMA
$ 811	Remainder
- 326	FMA
$ 485	Remainder
- 142	Medicare premium and doctor bill
$ 343	Resource and total contribution toward his care

The client has a $343 resource to contribute to his care. Because there is a community spouse, the spenddown amount determined in the eligibility process is not subtracted as a non-reimbursable medical expense and is not added to the resource to determine his total contribution.

NURSING CARE SERVICES

D. AFDC/U RECIPIENTS

When an AFDC/U recipient enters a nursing facility or an AFDC/U application is made, all eligibility requirements in Chapters 9 and 15 apply.

The nursing facility resident is included in the benefit group and $30 of the AFDC/U check is used for his personal needs allowance. Because benefit groups of 8 or more receive only the capped AFDC/U check amount of $477, a special needs allowance, as specified below, must be added to the AFDC/U check to ensure that the full personal needs allowance is available to the nursing care patient.

Benefit Group	Special Needs Allowance
8	$15, $50 or $75
9 or more	$30, $65 or $90

E. QUALIFIED MEDICARE BENEFICIARIES (QMB)

QMB recipients receive coverage for Medicare co-insurance payments and deductibles, which includes nursing care payment, when Medicare is participating in the cost of care. See Section 17.2.

F. APPLICATION OF TRUST AND TRANSFER OF RESOURCES POLICY

Because the trust and transfer of resources provisions which are effective for trusts and transfers established on or after 8/11/93 apply to all Medicaid Recipients, including SSI and Deemed SSI Recipients and AFDC/U Recipients, the Worker must contact the client or his representative to determine if these provisions apply. When either or both applies, the penalty is applied for as long as the trust exceeds the asset limit or until the transfer penalty period expires, or both, as appropriate.

BLOCK #	TITLE	MANDATORY ENTRY	MAX. LENGTH	ALPHA OR NUMERIC
45	RSDI INDICATOR	N	2	Alpha
46	RSDI Amount	N	4	Numeric

When the client receives RSDI benefits, enter SS in Block 45. Enter the total amount of the RSDI benefits, used to determine countable income, in Block 46.

ENTERED BY	FORCES RECALCULATION	AUTO REMOVED	PROGRAMS	INTERRELATED TO OTHER BLOCKS
Worker	N	Y	All, except PL pregnant women and children, QC's, and Newborns	39, 40, 49, 50, 51, 53, 58, 80
Worker	Y	Y		

BLOCK #	TITLE	MANDATORY ENTRY	MAX. LENGTH	ALPHA OR NUMERIC
65	Child Care Expenses	Y-NEWAP, REOPN	3	Numeric

Enter the amount of dependent care expenses the families of Poverty-Level, Qualified and Newborn children pay. Include the total amount paid, whether out of the client's pocket or not.

This Block is used for gathering statistical information only and has no effect on the benefit calculation.

ENTERED BY	FORCES RECALCULATION	AUTO REMOVED	PROGRAMS	INTERRELATED TO OTHER BLOCKS
Worker	N	N	PL, QC and Newborns	None

BLOCK #	TITLE	MANDATORY ENTRY	MAX. LENGTH	ALPHA OR NUMERIC
71	Non-Reimbursable Medical Expenses	N	5	Numeric

The amount of the client's non-reimbursable medical expenses (except the spenddown amount) is entered here for use in post-eligibility calculations. This amount is added to the spenddown amount in Block 67 and the total is subtracted from income during the post-eligibility process.

ENTERED BY	FORCES RECALCULATION	AUTO REMOVED	PROGRAMS	INTERRELATED TO OTHER BLOCKS
Worker	Y	N	NF, ICF/MR Residents in Medically Needy Cases	40, 46, 47, 48, 50, 51, 67, 70, 78, 79

BLOCK #	TITLE	MANDATORY ENTRY	MAX. LENGTH	ALPHA OR NUMERIC
78	LTC Resource Amount	N	5	Numeric

The system enters the result of post-eligibility calculations for Nursing Care and ICF/MR cases here.

When the client is a single individual who must contribute his spenddown amount to his cost of care, this is the amount, in addition to his spenddown, which he must contribute to his cost of care. This amount, plus the spenddown amount, is the client's total contribution which is placed in Block 51.

When the NF or ICF/MR client has a community spouse, this is the amount of his contribution to his cost of care and the amount is also placed in Block 51.

ENTERED BY	FORCES RECALCULATION	AUTO REMOVED	PROGRAMS	INTERRELATED TO OTHER BLOCKS
System	N	N	NF, ICF/MR	40, 46, 47, 48, 50, 67, 69, 70, 71, 79

- The appropriate MNIL is subtracted from the amount in Block 51. The remainder is multiplied by 6 to determine the excess income for the POC. This amount is entered in Blocks 58 and 80.

- An S is entered in Block 57.

- When incurred medical expenses and the dates they are incurred are entered by a WESDN transaction, the amount in Block 58 is reduced by the total expenses entered.

- When sufficient medical expenses are entered to reduce Block 58 to $0, the system takes the following actions

  - The S is removed from Block 57.

  - Beginning and ending dates of eligibility are entered in Blocks 9 and 10.

  - A medical card is issued.

- If sufficient medical expenses are not entered for the POC, the system automatically closes the case, effective the last month of the POC.

C. POST-ELIGIBILITY CALCULATIONS

The second prefix of the case is A, B or D. The client's total contribution toward his cost of care in a nursing facility or ICF/MR is determined as follows:

NOTE: The client's Medicaid eligibility must be determined outside the data system by the Worker. See Chapter 17.

Step 1: Income from Blocks 40, 46 and 50 is added together.

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Gaston Caperton
Governor

Gretchen O. Lewis
Secretary

LONG-TERM CARE INCOME ELIGIBILITY

1. $ _____ Total Gross Non-Excluded Monthly Earned Income

2. + _____ Total Gross Non-Excluded Monthly Unearned Income

3. $ _____ Total Gross Non-Excluded Monthly Income **

** If the amount on line 3 is equal to or less than 300% of the current maximum SSI payment for 1 person, the client is financially eligible for long-term care. Continue by determining the client's contribution toward his cost of care, if any.

If the amount on line 3 is more than 300% of the current maximum SSI payment for 1 person, the client is not eligible for HCB or MR/DD Waiver. Nursing facility and ICF/MR residents must spenddown before becoming eligible.

Current SSI Maximum Payment = _____
x 3
300% SSI Payment

LEMASTERS ET AL. REIMBURSEMENT

DATE: _____

TO: IM Policy Unit, Office of Family Support

FROM: _____

CASE NAME: _____

CASE NUMBER: _____

SSN: _____

MONTH	ACTUAL CONTRIBUTION	RECALCULATED CONTRIBUTION	AMOUNT DUE (Actual minus Recalculated)
TOTAL			

Attach computation sheets for each affected month.

MAIL CHECK TO:

_____

_____

_____

_____
WORKER **DATE**

_____
SUPERVISOR **DATE**