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DATE: August, 1995			**TO:** All Income Maintenance Manual Holders		

Changes are made to Chapters 17 and 23 as follows:

1. Chapter 17

Clarifications were added based on questions received by the IM Policy Unit. In addition, some typographical errors were corrected.

The major changes are listed below, but it is necessary to read the entire change for a full understanding of the policy.

- Section 17.2,A,2 was rewritten in an attempt to make the beginning date of payment for nursing care services a little clearer.
- Section 17.2,B was changed to address SSI recipients in nursing facilities.
- Form ES-NH-2 was revised and is now the IM-LTC-3.
- Section 17.8 now shows details of the eligibility groups.
- Proration of the client's monthly cost contribution for the first and last months of nf residence was added to Section 17.9,B.
- Section 17.9,D,1,e was changed in an attempt to make the non-reimbursable medical expenses policy clearer.
- Section 17.10,B,4 was reorganized.
- New Sections 17.10,B,6 and 7 describe treatment of life estates and annuities.
- New Section 17.10,C now contains policy about the homestead property exclusion which was previously omitted from the Manual even though the policy remained in effect.
- Section 17.11,B,1 was changed to show the meaning of codes appearing on the printout from the Level of Care Evaluator.

- Section 17.13 was NOT updated with information about new Estate Recovery procedures because the plans you were previously notified of have not yet been finalized. We continue to work with BMS to implement the plan.

2. Chapter 23

   While testing the data system changes for the new nursing care and ICF/MR policy, the function of Block 78 in the M-219 system was changed. Block 79 was increased to 3 positions in anticipation of an upcoming change. In addition, clarifications were added based on questions received and the Table of Contents was corrected.

Only 3 of the 82 questions in the memorandum of 11/6/95, LTC Question and Answer memorandum, still need to be addressed in the Manual. Questions 10, 14 and 67 have been added in separate Manual changes which have already been sent to print. We are still exploring the possibilities related to Question 42. Question 42 will not necessarily require a Manual change. Therefore, effective 4/1/96, when we expect the other changes will have been received, the memorandum of 11/6/95 will be obsolete.

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

HOME AND COMMUNITY BASED WAIVER (HCB)

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, but must refer the client, or representative to OMS, for specific information. The Worker must not contact OMS on behalf of the client, but must refer the client or representative to OMS.

The Worker must refer all inquiries about billing issues from the nursing or ICF/MR facility to Provider Services in OMS. The Worker must not contact OMS on behalf of the provider, but must refer the provider to OMS.

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

17.2 APPLICATION/REDETERMINATION

A. THE APPLICATION PROCESS

The application process for nursing care services is the same as the application process for the appropriate coverage group outlined in Chapter 1 with the following exceptions:

1. When Department Participates in Payment

The Department participates in the payment of nursing care services when it is established that:

- The patient is Medicaid eligible or, if pending spenddown, the spenddown amount is equal to or less than the facility rate.
- Nursing care is medically necessary.
- He is receiving care in a certified and Department-approved nursing facility.

2. Date of Eligibility

Payment for nursing care services begins on the earliest date the three following conditions are met simultaneously:

- The client is eligible for Medicaid; and

  NOTE: If the client is eligible as an SSI-Related Medicaid client, his spenddown is presumed to be met when the cost of his nursing care exceeds his spenddown amount. Thus, his Medicaid eligibility begins the first day of the month of application or the first day of the month, up to 3 months prior to the month of application, when coverage is backdated.

- The client resides in a nursing facility; and
- There is a valid PAS-95. See Section 17.11 for details about the PAS-95 and examples in addition to those below.

Payment for nursing care services may be backdated for up to 3 months prior to the month of

application, provided all of the conditions described above are met for that period.

EXAMPLE: An individual is a patient in a hospital. The physician recommends nursing care to the patient's family and completes a PAS-95 dated 6/5/95. The family is undecided about placing the individual in a nursing facility and takes the patient home to provide care. They do not apply for Medicaid until 8/16/95 which is the date the client enters the nursing facility. Medicaid eligibility is established beginning 8/1/95, but the PAS-95 has expired. A new PAS-95 is not completed until 8/22/95. Medicaid nursing care payments begin 8/22/95.

EXAMPLE: Same situation as above except that the PAS-95 is dated 6/25/95. A new PAS-95 is not required, but nursing care payments cannot begin until 8/16/95, which is the date he entered the nursing facility.

EXAMPLE: An individual enters a nursing facility on 8/16/95 and the PAS-95 is signed 8/16/95. However, the client does not become Medicaid eligible until 9/1/95 due to excess assets. Payment for nursing care services begins 9/1/95.

EXAMPLE: An individual enters a nursing facility on 10/10/95 and a PAS-95 is signed on that date. On 11/25/95 his family applies for Medicaid to pay for his nursing care costs. Medicaid eligibility is backdated to 8/1/95 to cover the cost of his recent hospitalization. Payment for nursing care services begins on 10/10/95.

3. Content Of The Interview

In addition to the requirements in Chapter 1, the Worker must screen the client according to the priorities listed in Section 17.9,C.

The Worker must explain to the client that the QMB approval is approval of a nursing care case when Medicare is participating in the cost of nursing care. The Worker must also explain the asset policy so he is aware that his accumulated income, which he would normally pay for his care, may result in ineligibility due to excess assets.

B. REDETERMINATION PROCESS

Redeterminations are the same for nursing care cases as they are for SSI-Related Medicaid, except that a full-scale redetermination is completed once a year, and a desk redetermination is alternated with a full-scale one.

NOTE: Because an ES-2 is not required at application, when a recipient of a combination of SSI and another income source is eligible for nursing care services, the first redetermination must be a full-scale one. Subsequent to the first redetermination, desk reviews are alternated with full-scale redeterminations.

1. Full-Scale Redeterminations

The redetermination is completed with the individual who is responsible for handling the client's affairs.

a. Representative Lives in Another State

If there is no one living in the State who handles the client's income and/or is knowledgeable about his affairs, the interview is conducted with the nursing facility staff member who has knowledge of the client's financial circumstances.

When the person handling the finances of a client lives too far to commute to a face-to-face interview, the Worker interviews the responsible person by telephone. The original ES-2 is mailed to the responsible person with a cover letter explaining the procedure for signing the form on the client's behalf. A copy is retained in the case record.

b. Representative Lives in Another County

When the representative to be interviewed lives in another county, the interview may be conducted in the office of the county in which he lives, at the nursing facility or in the office of the county in which the nursing facility is located. When the office in the county in which he lives agrees to conduct the interview, the procedure is as follows:

- 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

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each item and determines if action is required. If so, he checks yes in Action Required column and completes the action prior to completion of the redetermination. The form is self-explanatory.

Space for additional narrative recording and for preparing the case for terminal transmission is provided.

Identifying information is entered at the top of the first page. When the redetermination is completed, the Worker signs and dates the form.

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.

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/AC 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

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 the ineligible individual who is in a nursing facility becomes eligible for payment. A new form is prepared

when there is any change in the client's contribution toward his cost of care. The form is self-explanatory.

The ES-NH-3 is not a substitute for any client notification letter. When appropriate, the ES-NH-3 is attached to the ES-NL-A, ES-NL-B or ES-NL-C.

NOTE: Any time the client or his representative is notified of any changes in the client's eligibility, the nursing facility administrator must also be notified. If more than one nursing facility is involved, each administrator must be sent a copy of the ES-NH-3. When the client resides in more than one nursing facility in the same month and his contribution must be divided, see Section 17.9.

C. IM-NL-LTC-1

The IM-NL-LTC-1 is a calculation sheet used in determining eligibility based on 300% SSI payment. It is also used to determine the client's contribution in the post-eligibility process, regardless of the method by which he was determined eligible. It must be sent to the client or his representative with forms ES-NL-A, ES-NL-B, ES-NL-C and ES-NH-3 for notification of all case activity involving income eligibility.

D. IM-NL-LTC-2

The IM-NL-LTC-2 is a calculation sheet used to determine the CSMA and FMA for nursing care cases. It must be sent to the client or his representative with forms ES-NL-A, ES-NL-B, ES-NL-C and ES-NH-3 for notification when there is a change in the CSMA or the FMA.

E. ES-NL-D

The ES-NL-D is used to notify the client that the results of a spousal assessment cannot be appealed unless an application for nursing care is made. See Section 17.10. Form ES-NL-AC-1 must be mailed with the ES-NL-D.

F. ES-NL-AC-1

This form is used to complete an Asset Assessment. See Section 17.10.

17.7 COMMON ELIGIBILITY REQUIREMENTS

Individuals receiving payment for nursing care services must meet all common eligibility requirements in Chapter 8.

The eligibility requirement of residency is explained in detail in this Section. The requirement of residency is met when the recipient is living, not visiting, in West Virginia with the intention of remaining permanently or for an indefinite period.

Only a competent adult has the ability to express intent. An individual age 21 or over is presumed competent unless there is medical evidence to establish:

- An IQ of 49 or less; or
- A mental age of 7 or less; or
- Legal incompetence.

When the client is institutionalized, the client's intent is used to determine the state of residence.

When an individual is placed in a nursing facility or institution in one state by a state agency in another state, he retains his residence in the state making the placement.

For any institutionalized individual, age 21 or over, who is incapable of expressing intent and was not placed by a state agency, the state of residence is the state in which the individual is living.

The state of residence for an institutionalized individual under age 21 is the state of residence of the child's parent(s) or legal guardian, if they currently live in the same state. If the child and his parent(s)/legal guardian do not live in the same state, the state the parent(s)/legal guardian lived in at the time the child was institutionalized is the child's state of residence. If a minor child has married or in some other way becomes emancipated, the child is considered capable of expressing intent.

17.8 ELIGIBILITY DETERMINATION GROUPS

Medical eligibility may be determined under any full Medicaid coverage group using the eligibility determination groups for the appropriate coverage group. See Section 17.9,C and Chapter 9. If the client is not eligible for a full Medicaid coverage group, the following eligibility determination groups are used.

A. THE BENEFIT GROUP

1. Who Must Be Included

The institutionalized individual must be included.

2. Who Cannot Be Included

Only the institutionalized individual is included. An eligible spouse must be in his own benefit group, whether he is also institutionalized or not.

B. THE INCOME GROUP

Only the non-excluded income of the institutionalized individual is used to determine his eligibility.

C. THE NEEDS GROUP

- Compare the client's own total gross non-excluded monthly income to 300% of the monthly maximum SSI payment for one person; or

- For an SSI-Related Medicaid individual, use the MNIL for one person to determine the spenddown amount. See Section 17.9,C.

D. CASE COMPOSITION

The case is composed of the institutionalized individual. An eligible spouse is in his own case, whether he is also institutionalized or not.

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17.9 INCOME

There is a two-step income process for providing Medicaid coverage for nursing care services to individuals in nursing facilities. The client must be eligible for Medicaid by being a member of a full Medicaid coverage group, by being a QMB recipient or by meeting a special income test. See Chapter 16 to determine which coverage groups provide full Medicaid coverage. If the client has a spenddown, it must be met before he is eligible for nursing care services or it must be able to be met by the cost of the nursing care. Once Medicaid eligibility is established, the client's contribution toward his cost of care in the facility is determined in the post-eligibility process. These processes are described in item D below.

A. EXCLUDED INCOME SOURCES

Income sources that are excluded for the coverage group under which eligibility is determined are also excluded in the post-eligibility process for nursing care services. See Chapter 10, Section 10.3 for the appropriate coverage group.

B. BUDGETING METHOD

See Chapter 10, Section 10.6,B. A monthly amount of income is determined based on averaging and converting income from each source.

Regardless of the day of the month on which the client enters or leaves the nursing facility, all income the client is determined to have, according to Chapter 10, for each month he resides even one day in the facility must be counted in determining eligibility and in post-eligibility calculations. No deductions or exclusions are allowed for income already spent in the month the client enters the nursing facility or for expenses he anticipates in the month he leaves.

During the first month and last month that Medicaid participates in the cost of care, it is necessary to prorate the client's contribution to his care when he does not spend the full calendar month in the facility. This proration is accomplished as follows:

- Determine the client's total monthly cost contribution amount as for any other nf resident who expects to remain in the facility a full month.

- Divide the client's total monthly cost contribution by the actual number of days in the calendar month. This becomes the client's daily contribution rate, which is used for this purpose only.

- Determine the number of days the client resided or expects to reside in the facility in the calendar month and multiply the number of days by the daily contribution rate. The result is the client's total cost contribution for the partial month. After all computations have been completed, any cents calculated as part of the result are dropped.

NOTE: This policy applies only to the first and last months of nf residence when Medicaid participates in the payment. It is not used when the client leaves the facility for other medical treatment, for family visits, etc. During all other months, the client must contribute his full resource and be reimbursed by the facility if an overpayment occurs.

During the first month of Medicaid participation in the cost of care, when the client is not in the facility for a full month, the Worker may be asked how much the client is to retain for his personal needs and how much may be contributed to the community spouse and other family members. The process used to determine the Worker's response follows:

- Determine the client's total monthly Personal Needs Allowance (PNA), CSMA or FMA as if the client were to remain in the facility a full month.

- Divide the client's monthly PNA, CSMA or FMA by the actual number of days in the calendar month. This becomes the client's daily deduction rate which is used for this purpose only.

- Determine the number of days in the calendar month the client expects to reside in the facility and multiply the number of days by the daily deduction rate of the specific deduction. The result is the amount of income the client may retain for the PNA, CSMA or FMA. After all computations have been

completed, any cents calculated as part of the result are rounded up.

C. FINANCIAL ELIGIBILITY PROCESS

Eligibility for payment for nursing care services is determined in any of the following four ways, in the following priority order:

1. QMB Eligible

When a client needs nursing care services and Medicare is participating in the payment or will participate when the client enters the nursing facility, it may be to the client's advantage to receive payment for nursing care services as a QMB eligible, until Medicare no longer participates. The QMB medical card pays all Medicare co-insurance and deductibles, and QMB recipients are exempt by law from the post-eligibility process. They, therefore, have no contribution toward their cost of nursing care services as long as Medicare participates in the payment. See Chapter 16.

However, when the client would be disadvantaged in any way by QMB eligibility as opposed to eligibility under another coverage group, the Worker must use one of the following ways to determine eligibility, if one is more beneficial to him. In addition, when Medicare stops participating in the cost of care, QMB eligibility no longer covers nursing care costs and eligibility must be redetermined according to item 2, 3 or 4 below.

2. Client Is Medicaid Recipient

When the client is a recipient, under a coverage group which provides full Medicaid coverage, at the time he is determined to need nursing care services, his Medicaid eligibility has already been determined, and no further eligibility test is necessary. The Worker must complete only the post-eligibility calculations to determine the client's contribution toward his cost of care, if any.

All Medicaid coverage groups listed in Chapter 16 are full Medicaid coverage groups, unless there is a statement specifically to the contrary.

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Medically Needy individuals must be receiving a Medicaid card to be determined eligible under this provision.

Those Medically Needy individuals who have no spenddown meet the requirement of Medicaid eligibility. Those who meet their spenddowns prior to the need for nursing care, have met the requirement of being eligible, through the current POE. After the POE during which nursing care services begin, the client's situation is treated according to item 3 or 4 below. Those who do not meet their spenddowns prior to the need for nursing care are treated according to item 3 or 4 below.

When an applicant is not a recipient of full Medicaid coverage, the following test is made to determine eligibility.

3. Gross Income Test

If the client is not eligible under items 1 or 2 above, Medicaid eligibility may be established as follows:

- Determine the client's gross non-excluded monthly income.

- Compare the income to 300% of the current maximum SSI payment for one person.

To be Medicaid eligible, his income must be equal to or less than 300% of the SSI payment.

Once Medicaid eligibility is established in this manner, the client's contribution toward his cost of care is determined in the post-eligibility process. There is no spenddown amount for persons determined eligible in this way.

EXAMPLE: When the current maximum SSI payment is $470, the client's gross, non-excluded monthly income is compared to $1,410.

NOTE: SSI-Related Medicaid disability and asset guidelines must be met.

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 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.

D. POST-ELIGIBILITY PROCESS

In determining the client's contribution toward his cost of nursing care, the Worker must apply only the income deductions listed below. This is the post-eligibility process. The remainder, after all allowable deductions, is the resource amount, which is at least part of the amount the client must contribute toward his cost of care. The client's spenddown amount, if any, as determined in item C,4 above, is added to this amount to

determine the client's total contribution toward his nursing care. See item 2 below.

1. Income Disregards and Deductions

Only the following may be deducted from the client's gross, non-excluded income in the post-eligibility process:

a. Personal Needs Allowance

This amount is subtracted from income to cover the cost of clothing and other personal needs of the nursing facility resident. The monthly amount deducted is $30. However, for an individual who is entitled to the reduced VA pension of $90, the monthly Personal Needs Allowance is $90.

b. Community Spouse Maintenance Allowance (CSMA)

When the institutionalized individual has a spouse living in the community, a portion of his income may be deducted for the support of the spouse at home.

The minimum CSMA is 150% of the monthly FPL for two people. This amount is increased by excess shelter/utility expenses. The income of the community spouse is subtracted from this amount to determine the amount of the institutionalized spouse's income which can be used to meet his community spouse's needs.

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,

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Appendix B. The shelter cost must be from the home the institutionalized spouse and the community spouse shared prior to institutionalization, and in which the community spouse continues to live. It must have been the client's principal place of residence. Shelter costs include rent or mortgage payments, interest, principal, taxes, insurance and required maintenance charges for a condominium or cooperative.

Step 2: Compare the total of the costs in Step 1 to 30% of the minimum CSMA. See Chapter 10, Appendix A. When the shelter/utility costs exceed 30% of the minimum CSMA, subtract the 30% amount from the shelter/utility costs.

Step 3: Add the remainder from Step 2 to the minimum CSMA. See Chapter 10, Appendix A.

Step 4: Add together the community spouse's gross, non-excluded earned and unearned income.

Step 5: Subtract the Step 4 amount from the amount determined in Step 3 and if there are any cents, round the resulting amount up. This is the amount subtracted from the income of the institutionalized spouse for the needs of his community spouse.

If the Step 4 amount is equal to or greater than the Step 3 amount, no deduction is allowed.

NOTE: The total amount subtracted for the community spouse from the nursing facility patient's income must not exceed the maximum amount found in Chapter 10, Appendix A.

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c. Family Maintenance Allowance (FMA)

When the institutionalized individual has family members who are living with the community spouse and who are financially dependent upon him, an FMA is deducted from his income. This amount is deducted whether or not the individual actually provides the money to the family members.

For purposes of this deduction, family members are the following people only: minor or dependent children, dependent parents of either spouse and dependent siblings of either spouse. This deduction is applied only when the institutionalized individual has a community spouse, and such family members live with the community spouse.

The amount of the deduction is determined as follows for each family member:

Step 1: Subtract the family member's total gross non-excluded income from the minimum CSMA. See Chapter 10, Appendix A. If the income is greater than the minimum CSMA, no deduction is allowed for that member.

Step 2: Divide the remaining amount by 3, and round the resulting amount up.

EXAMPLE: $201.07 = $202

Step 3: Add together the individual deductions for all family members to determine the total FMA which is deducted from the income of the institutionalized individual.

NOTE: The FMA for each family member must not exceed one-third of the minimum CSMA.

d. Outside Living Expenses (OLE)

Single individuals and couples, when both spouses are institutionalized, receive a $175 deduction from income for maintenance of a home when a physician has certified in writing that

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, 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.

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

NOTE: 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.

2. Determining The Client's Total Contribution

Because the amount of medical expenses used to meet the client's spenddown cannot be paid by Medicaid, the spenddown amount becomes part of the client's contribution toward his cost of care. This amount is added to the resource amount determined in item 1. above to determine the client's total monthly contribution toward the cost of his nursing care.

If the client is Medicaid eligible without a spenddown according to items C,2 and C,3 above, the

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resource amount from item 1 is his total cost contribution.

When the client resides in more than one nursing care facility during the same calendar month, the Worker must determine the portion of the client's cost contribution which must be paid to each facility. The Worker follows the steps below to determine how much of the client's total contribution must be paid to the first facility he entered. If the client's total contribution must be paid to Facility #1, no further calculation is necessary. If not, the amount(s) paid to the other(s) is determined in the same way. The ES-NH-3 is used for notification of the amount due each facility.

Step 1: Determine the client's monthly contribution toward his cost of care.

17.10 ASSETS

A nursing care client must meet the asset test for his eligibility coverage group. The asset level for those eligible by having income equal to or less than 300% SSI payment for an individual is the same as for an SSI-Related Medicaid eligible. See Chapter 11 for the appropriate coverage group.

Once the Worker determines the value of the assets, there are additional procedures that apply to nursing care clients.

A. ASSET ASSESSMENTS

NOTE: A legally married individual and his spouse, although separated, are treated as a couple for the asset assessment, regardless of the length of the separation.

When determining eligibility for nursing care services for an individual, institutionalized on or after 9/30/89, who has a community spouse, the Worker must complete an assessment of the couple's combined countable assets. The assessment is completed, when requested by the client or his representative, prior to application, or at application, if not previously completed. It is completed as of the first continuous period of institutionalization and is completed one time only.

The assessment is done on Form ES-NL-AC-1. The purpose of the spousal asset assessment is to allow the spouse of an institutionalized individual to retain a reasonable portion of the couple's assets.

When requested, the Worker must advise the individual(s) of the documentation required for the assessment. Verification of ownership and the CMV must be provided. When it is not provided, the assessment is not completed.

The Worker documents the total value of all non-excluded assets.

Nursing facilities are required to advise all new admissions and their families that asset assessments are available upon request from the county office. The agency has developed a statement concerning the availability of asset assessments. Nursing facilities provide this "Patient's Bill of Rights" as part of their admission package. See Appendix C.

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1. Calculation Of The Spouses' Shares

The spouses' shares are computed as follows:

Step 1: Determine the CMV of the couple's combined countable assets, as of the beginning of the first continuous period of institutionalization.

Step 2: Compare the amount from Step 1 to $15,348. If the Step 1 amount is equal to or less than $15,348, all assets are attributed to the community spouse. If not, go to Step 3.

Step 3: Divide the Step 1 amount by 2 and compare to $15,348. If one-half of the Step 1 amount is equal to or less than $15,348, the community spouse is attributed $15,348 and the remainder belongs to the institutionalized spouse. If not, go to Step 4.

Step 4: When one-half of the Step 1 amount is greater than $15,348, one-half of the total assets (Step 1 amount) is attributed to the community spouse, not to exceed $76,740.

Step 5: The amount not attributed to the community spouse is attributed to the institutionalized spouse.

If an application for nursing care services is not made when the assessment is completed, the spouse retains the amount attributed to him at the assessment, regardless of the couple's combined assets at the time of application.

2. Notification Requirements

When the assessment is complete, the Worker must provide each member of the couple with a copy of the ES-NL-AC-1. A copy is retained in the case record. The assessment is entered in the SAS system for future reference. See item 7 below.

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The Worker must also notify the community spouse using form ES-NL-D that the assessment may not be appealed until a Medicaid application is made.

3. Revisions To The Asset Assessment

The asset assessment may be revised when the client, his spouse, the Hearings Officer or the Worker determine, with supporting documentation, that the initial determination was incorrect or based on incorrect information.

4. Additional Asset Exclusions For Institutionalized Spouses

The institutionalized individual is not ineligible for Medicaid due to the assets determined above, if he lacks the ability to or is legally prevented from assigning the assets which would otherwise make him ineligible. In addition, when denial of Medicaid eligibility will work an undue hardship, his assets may be excluded. See Chapter 11 for the definition of undue hardship.

5. Transfers of Assets To The Community Spouse

Once initial eligibility has been established, assets that were not counted for the institutionalized spouse must be legally transferred to the community spouse. Assets cannot merely be attributed to the community spouse, but must actually be transferred to the community spouse, if they are to be excluded in determining continuing Medicaid eligibility of the institutionalized spouse. Assets legally transferred to the community spouse are not treated as uncompensated transfers of resources.

To exclude assets attributed to the community spouse, the institutionalized spouse must indicate his intent to transfer the assets to the community spouse, and the transfer must take place within 90 days, unless a longer period is required to take the action.

6. Additional Asset(s) Received/Obtained

When the institutionalized spouse obtains an additional asset(s) after the community spouse's

share has been calculated and initial Medicaid eligibility is established, the additional asset(s) is excluded when one of the following conditions exist:

- The new asset(s), combined with the other assets the institutionalized spouse intends to retain, does not exceed the asset limit for one person; and/or

- The institutionalized spouse intends to transfer the new asset(s) to the community spouse who has assets below the previously determined spousal amount. To exclude the additional asset(s), the institutionalized spouse or his representative must promptly report receipt of the new asset(s) and provide the Worker with a written statement that he intends to transfer the new asset(s) to the community spouse within 90 days.

  The assets of the community spouse may still not exceed the amount determined in the previous Asset Assessment. This criteria would come into play when another asset of equal or greater value than the additional one(s) is no longer owned.

7. SAS System Entries

When an asset assessment is completed, the Worker must enter the results in a data system SAS file.

The screen shows the following information about the institutionalized spouse: name, SSN, sex, case number, if applicable, nursing facility vendor code, community spouse's name and address, date of admission, amount of total assets, community spouse's share of assets and the county that completed the assessment. See Appendix D.

B. TRANSFER OF RESOURCES

Four policies dealing with the transfer of assets and/or income are addressed in this Chapter. The current policy is detailed below. The other three are contained in Appendix A. They are:

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- Transfers made by the Medicaid benefit group on or before June 30, 1988

- Transfers made by the Medicaid benefit group after June 30, 1988

- Transfers made on or after July 1, 1988 when application for Medicaid eligibility for nursing care services, ICF/MR Services or the HCB Waiver is made

the home for at least one year immediately prior to the client's institutionalization.

- To the client's child who was residing in the home for at least two years immediately prior to the client's institutionalization and who provided care to the individual which allowed him to remain at home rather than being institutionalized.

b. Other Transfers

When the client transfers resources other than his home, as follows, no penalty is applied:

- To the client's spouse or to another person for the sole benefit of the client's spouse

- From the client's spouse to another person for the sole benefit of the client's spouse

- To the client's disabled child. See definition of disabled above in item a.

c. Transfer to a Trust

When the client or his spouse transfers resources to a trust that is excluded from consideration as an asset, no penalty is applied. See Chapter 11.

d. Transferred Resources Returned

When all assets transferred for less than FMV have been returned to the client, no penalty is applied. However, if a penalty has already been applied, a retroactive adjustment back to the beginning of the penalty period is required. The client is not necessarily asset-eligible once the resources are returned.

If part of such assets are returned, the penalty period is adjusted accordingly.

e. Client Intended Fair Market Return or Other Valuable Consideration

When the client or his spouse can demonstrate that he intended to dispose of the resource for FMV or for other valuable consideration, no penalty is applied.

f. Transfer Was Not To Qualify For Medicaid

When the resources were transferred exclusively for a purpose other than to qualify for Medicaid, no penalty is applied.

g. Denial Would Result in Undue Hardship

When it is determined that denial of eligibility would work an undue hardship on the client, no penalty is applied. Decisions about what constitutes undue hardship are made by the Director of OFS. Requests for consideration must be submitted in writing with details about the anticipated undue hardship.

5. Transfers Which Are Not Permissible

All transfers not specifically excluded from the application of a penalty result in application of a penalty. This also applies to jointly owned resources. The jointly owned resource, or the affected portion of it, is considered transferred by the client when any action is taken, either by the client or any other person, that reduces or eliminates the client's ownership or control of the resource.

6. Transfer With Retention of A Life Estate

A transfer of property with the retention of a life estate interest is treated as an uncompensated transfer.

To determine if a penalty is assessed and the length of the penalty, the Worker must compute the value of the transferred asset and of the life estate, then calculate the difference between the two.

Step 1: To determine the value of the transferred asset, subtract any loans, mortgages or other encumbrances from the CMV of the transferred asset.

Step 2: Determine the age of the life estate holder as of his last birthday and the life estate factor for that age found in Appendix A of Chapter 11. Multiply the CMV of the transferred asset by the life estate factor. This is the value of the life estate.

Step 3: Subtract the Step 2 amount from the Step 1 amount. The result is the uncompensated value of the transfer.

Step 4: Divide the Step 3 amount by the State's average, monthly nursing care private pay rate. The result is the length of the penalty.

7. Transfer To Purchase An Annuity

Establishment of an annuity is sometimes treated as a transfer of resources, depending on whether or not the annuity is actuarially sound. The average number of years of expected life remaining for the individual who benefits from the annuity must coincide with the life of the annuity for it to be actuarially sound and, thus, not treated as an uncompensated transfer of resources. If the individual is not reasonably expected to live longer than the guarantee period of the annuity, the individual will not receive FMV. The annuity is not, then, actuarially sound and a transfer of resources for less than FMV has taken place.

The penalty is considered to have occurred at the time the annuity was purchased. Only the amount that is not actuarially sound is treated as an uncompensated transfer. Life Expectancy Tables by sex are found in Appendix E.

EXAMPLE: A 65-year-old man purchases a $10,000 annuity which is to be paid over 10 years. His life expectancy, according to Appendix E, is 14.96 years. The annuity is actuarially sound so no transfer of resources has taken place.

EXAMPLE: An 80-year-old man purchases a $10,000 annuity to be paid over 10 years. According to Appendix E, his life expectancy is only 6.98 years. Therefore, the amount which will be paid out by the annuity for 3.02 years is considered an uncompensated transfer of resources which took place at the time the annuity was purchased.

8. Transfer Penalty

The transfer of resources penalty is ineligibility for:

- Nursing care services, and
- A level of care in any institution, equivalent to that of nursing care services, and
- Home and Community Based Waiver services.

The penalty is applied as follows. The client may remain eligible for Medicaid; services not subject to a penalty are paid.

a. Start of the Penalty

The penalty period starts the month in which the resource is transferred, as long as that month does not occur in any other period of ineligibility due to a transfer of resources penalty. If the month the resource is transferred falls into another such penalty period, the penalty period begins the month after the previous penalty period ends.

When a single resource is transferred, or a number of resources are transferred at the same time, the penalty period is determined by adding together the total uncompensated value of the resource(s) and dividing as shown below. When resources are transferred at different times, the following general guidelines are used.

(1) When Penalty Periods Would Overlap

When resources have been transferred in amounts and/or frequency that would make the calculated penalty periods overlap,

add together the value of all resources transferred, and divide by the average cost of nursing care services. This produces a single penalty period which begins on the first day of the month in which the first transfer was made.

EXAMPLE: An individual transfers $10,000 in January, $10,000 in February and $10,000 in March. Calculated individually, based on a nursing care cost of $2,585 a month, the penalty for the first transfer is from January through March, the second is from February through April and the third is from March through May. Because these periods overlap, the Worker must calculate the penalty periods by adding the transfers together (a total of $30,000) and dividing by the nursing care cost ($2,585). The penalty period of 11 months, which runs from January 1 through November 30.

(2) When Penalty Periods Would Not Overlap

When multiple transfers are made in such a way that the penalty periods for each would not overlap, the Worker must treat each transfer as a separate event, with its own penalty period.

EXAMPLE: An individual transfers $5,000 in January, $5,000 in May and $5,000 in October. Assuming an average private

If the penalty period is not equally divisable, assign the extra month in the penalty period to the spouse who actually transferred the resource.

When the penalty period is divided between spouses, the total penalty period applied to both spouses must not exceed the total penalty which remained at the time the penalty was divided.

When, for any reason, one spouse is no longer subject to a penalty, such as, when the spouse no longer receives nursing care services, or dies, the penalty period which was remaining for both spouses must be served by the remaining spouse.

d. Application of the Penalty

Since the penalty for transferring resources is not total ineligibility for Medicaid, it is possible that the client is eligible for all Medicaid services except nursing care, ICF/MR and Home and Community Based Waiver care. When this happens, the procedure upon which data system the case is in.

(1) M-219 System

The Worker must code a 1 in Block 77. See Chapter 23.

(2) C-219 System

The Worker must have the medical card sent to the county office each month the penalty is applied. Once received, the following statement must be typed on the card: Not Valid For Nursing Level Of Care. The card, with the typed statement, must be mailed to the client the same day it is received.

9. Treatment Of The Transfer Of A Stream Of Income

When the client fails to take action necessary to receive income or transfers the right to receive income to someone else for less than

CMV, the transfer of resources penalty is applied. The Worker must:

Step 1: Verify the amount of potential annual income.

Step 2: Using the client's age as of his last birthday, determine the Remainder Interest Value in Appendix B.

Step 3: Multiply the Step 2 amount by the Step 1 amount to determine the uncompensated value.

Step 4: The result from Step 3 is divided by the average monthly nursing facility private pay rate for the State to determine the penalty period.

10. Treatment Of Jointly Owned Resources

Jointly owned resources include resources held by an individual in common with at least one other person by joint tenancy, tenancy in common, joint ownership or any similar arrangement. Such a resource is considered to be transferred by the individual when any action is taken, either by the individual or any other person, that reduces or eliminates the individual's ownership or control of the asset.

Under this policy, merely placing another person's name on an account or resource as a joint owner might not constitute a transfer of resources, depending upon the specific circumstances involved. In such a situation, the client may still possess ownership rights to the account or resource and, thus, have the right to withdraw all of the funds at any time. The account, then, still belongs to the client. However, actual withdrawal of funds from the account, or removal of all or part of the resource by another person, removes the funds or property from the control of the client, and, thus, is a transfer of resources. In addition, if placing another person's name on the account or resource actually limits the client's right to sell or otherwise dispose of

it, the addition of the name constitutes a transfer of resources.

If either the client or the other person proves that the funds withdrawn were the sole property of the other person, the withdrawal does not result in a penalty.

C. HOMESTEAD PROPERTY EXCLUSION

When a nursing facility resident indicates his intention of returning to his homestead property when/if discharged, the homestead property is excluded as an asset. If the client is incapable of indicating his intent, his Committee, legal representative or the person handling his finanical matters will make the determination on his behalf.

It is not necessary that the client be medically able to return home to apply the exclusion. The exclusion is based solely on the client's intended action, should he be discharged from the facility. The Worker must record the client's statement of intent in the case record. A written statement may be requested, but no action may be taken to deny or stop benefits for failure to provide a written statement when the client has expressed his intent verbally or by gesture.

If the client's homestead is a multi-unit dwelling, such as an apartment building, the entire property is excluded, not just the portion of the value which corresponds to the portion of the property in which he actually lived.

The homestead property may not be in West Virginia. The homestead exclusion applies, regardless of the state in which it is located. The client's expressed intent to return to the homestead property does not necessarily affect his West Virginia residency. See Chapter 8.

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17.11 ESTABLISHING MEDICAID CATEGORICAL RELATEDNESS AND THE MEDICAL NECESSITY FOR NURSING CARE

A. ESTABLISHING MEDICAID CATEGORICAL RELATEDNESS

When the applicant for nursing care services is not a recipient of Medicaid under a full Medicaid coverage group, categorical medicaid eligibility, as well as financial eligibility, must be established.

Incapacity, disability or blindness, when not already established by the receipt of RSDI or Railroad Retirement benefits based on disability, must be established by MRT.

All procedures in Chapter 12 for a MRT referral for the appropriate coverage group are applicable, and a presumptive approval may be made according to the guidelines in that Chapter.

NOTE: The PAS-95 does not establish incapacity or disability. However, a copy of the PAS-95 may be submitted to MRT as medical information.

B. ESTABLISHING MEDICAL NECESSITY, THE PAS-95

1. When The PAS-95 Is Completed

Before payment for nursing care services can be made, medical necessity must be established. The PAS-95 is used for this purpose. The PAS-95 is signed by a physician and is evaluated by a medical professional of the State's contracted level of care evaluator. The PAS-95 is valid for 60 days from the date the physician signs the form. The 60-day validity period applies, regardless of the reason for completion, i.e., new admission, transfer to a different facility.

NOTE: The date the PAS-95 is completed for the purpose of establishing medical necessity is the date the physican signs the form, not the date of any other determination made using the PAS-95.

The PAS-95 is completed when:

- The individual enters a Medicaid certified facility.

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- County
- Originating facility
- Physicians assessment date
- Review results
  - A = Nursing care needed
  - B = Personal care needed
  - C = No services needed

– Forward the original PAS-95 to the appropriate agency for the Level II evaluation when the presence of mental illness/retardation is indicated. See item e.

When the review results of a PAS-95 do not appear on the printout, the Worker must obtain a copy of the form.

d. Responsibilities of the Worker

Forward the original PAS-95 to the level of care evaluator when the PAS-95 is received in the county office before being sent to the level of care evaluator.

e. Level II PASARR

Any individual who applies for nursing care services in a Medicaid-certified facility must be evaluated for the presence of mental illness/retardation or related conditions, as well as for the need for specialized services to address the individual's mental health needs. The level of care evaluator, after making the Level I decision of medical necessity, forwards the PAS-95 to the mental health evaluator, if appropriate.

The date of the Level II evaluation has no bearing on the date that medical necessity for nursing care is established. See item A above.

17.12 SPECIAL PROCEDURES RELATED TO COVERAGE GROUPS

A. SSI RECIPIENTS WITH NO OTHER INCOME

Notify SSA, using the HS-3, when the SSI recipient enters or leaves a nursing home. The SSI Medicaid case must be properly coded for nursing care services. See Section 17.14. The date that eligibility for nursing care services is established, regardless of Medicare participation, is coded in the data system.

When the institutionalized SSI recipient has an Essential Spouse (See Chapter 16) who is included in the benefit group and who appears on the same medical card, the Essential Spouse remains on the medical card and in the case until one or both individuals appears on the SDX Need to Evaluate printout. Appropriate action is taken on the case at that time. Until notified of the status of the Essential Spouse, the medical card is sent to the spouse who remains at home.

B. SSI RECIPIENTS WITH OTHER INCOME

Notify SSA, using the HS-3, when the SSI recipient enters or leaves a nursing facility. When an SSI recipient with other income enters a nursing facility and is eligible for payment for his care, a case is opened in the M-219 system so that a resource amount is computed. The C-219 system case is closed. When the client becomes ineligible for nursing care services, his SSI Medicaid case must be reopened. When the institutionalized SSI recipient has an Essential Spouse (See Chapter 16), who is included in the benefit group and who appears on the same medical card, the C-219 system case remains active for the Essential Spouse only.

C. DEEMED SSI RECIPIENTS

Deemed SSI Recipients receive Medicaid in the C-219 system, even though they do not receive SSI. When the Deemed SSI Recipient enters a nursing facility and is eligible for payment for his care, a case is opened in the M-219 system so that a resource amount is computed. The C-219 system case is closed.

When the client becomes ineligible for nursing care services, his Medicaid case as a Deemed SSI Recipient must be reopened.

APPENDIX E

LIFE EXPECTANCY TABLE

MALES

Age	Expectancy	Age	Expectancy	Age	Expectancy
0	71.80	40	35.05	80	6.98
1	71.53	41	34.15	81	6.59
2	70.58	42	33.26	82	6.21
3	69.62	43	32.37	83	5.85
4	68.65	44	31.49	84	5.51
5	67.67	45	30.61	85	5.19
6	66.69	46	29.74	86	4.89
7	65.71	47	28.88	87	4.61
8	64.73	48	28.02	88	4.34
9	63.74	49	27.17	89	4.09
10	62.75	50	26.32	90	3.86
11	61.76	51	25.48	91	3.64
12	60.78	52	24.65	92	3.43
13	59.79	53	23.82	93	3.24
14	58.82	54	23.01	94	3.06
15	57.85	55	22.21	95	2.90
16	56.91	56	21.43	96	2.74
17	55.97	57	20.66	97	2.60
18	55.05	58	19.90	98	2.47
19	54.13	59	19.15	99	2.34
20	53.21	60	18.42	100	2.22
21	52.29	61	17.70	101	2.11
22	51.38	62	16.99	102	1.99
23	50.46	63	16.30	103	1.89
24	49.55	64	15.62	104	1.78
25	48.63	65	14.96	105	1.68
26	47.72	66	14.32	106	1.59
27	46.80	67	13.70	107	1.50
28	45.88	68	13.09	108	1.41
29	44.97	69	12.50	109	1.33
30	44.06	70	11.92	110	1.25
31	43.15	71	11.35	111	1.17
32	42.24	72	10.80	112	1.10
33	41.33	73	10.27	113	1.02
34	40.23	74	9.27	114	0.96
35	39.52	75	9.24	115	0.89
36	38.62	76	8.76	116	0.83
37	37.73	77	8.29	117	0.77
38	36.83	78	7.83	118	0.71
39	35.94	79	7.40	119	0.66

APPENDIX E

LIFE EXPECTANCY TABLE

FEMALES

Age	Expectancy	Age	Expectancy	Age	Expectancy
0	78.79	40	40.61	80	9.11
1	78.42	41	39.66	81	8.58
2	77.48	42	38.72	82	8.06
3	76.51	43	37.78	83	7.56
4	75.54	44	36.85	84	7.08
5	74.56	45	35.92	85	6.63
6	73.57	46	35.00	86	6.20
7	72.59	47	34.08	87	5.79
8	71.60	48	33.17	88	5.41
9	70.61	49	32.27	89	5.05
10	69.62	50	31.37	90	4.71
11	68.63	51	30.48	91	4.40
12	67.64	52	29.60	92	4.11
13	66.65	53	28.72	93	3.84
14	65.67	54	27.86	94	3.59
15	64.68	55	27.00	95	3.36
16	63.71	56	26.15	96	3.16
17	62.74	57	25.31	97	2.97
18	61.77	58	24.48	98	2.80
19	60.80	59	23.67	99	2.64
20	59.83	60	22.86	100	2.48
21	58.86	61	22.06	101	2.34
22	57.89	62	21.27	102	2.20
23	56.92	63	20.49	103	2.06
24	55.95	64	19.72	104	1.93
25	54.98	65	18.96	105	1.81
26	54.02	66	18.21	106	1.69
27	53.05	67	17.48	107	1.58
28	52.08	68	16.76	108	1.48
29	51.12	69	16.04	109	1.38
30	50.15	70	15.35	110	1.28
31	49.19	71	14.66	111	1.19
32	48.23	72	13.99	112	1.10
33	47.27	73	13.33	113	1.02
34	46.31	74	12.68	114	0.96
35	45.35	75	12.05	115	0.89
36	44.40	76	11.43	116	0.83
37	43.45	77	10.83	117	0.77
38	42.50	78	10.24	118	0.71
39	41.55	79	9.67	119	0.66

BLOCK #	TITLE	MANDATORY ENTRY	MAX. LENGTH	ALPHA OR NUMERIC
51	Countable Income/LTC Total Contribution	N/A	4	Numeric

For nursing care and ICF/MR cases, this Block is the system-determined, total amount of the client's contribution toward his cost of care. It is the total of Blocks 67 and 78.

For all others, this is the system-determined monthly amount of countable income.

ENTERED BY	FORCES RECALCULATION	AUTO REMOVED	PROGRAMS	INTERRELATED TO OTHER BLOCKS
System	N/A	Y	All except PL pregnant women, QC, Newborns	40, 46, 47, 50, 53, 67, 70, 71, 78, 79, 51, 48

BLOCK #	TITLE	MANDATORY ENTRY	MAX. LENGTH	ALPHA OR NUMERIC
52	Health Insurance Indicators	N	1	Alpha

Enter Y or N to indicate whether or not the client has health insurance coverage other than Medicaid.

This is used by BMS to identify potential sources of payment of medical expenses.

ENTERED BY	FORCES RECALCULATION	AUTO REMOVED	PROGRAMS	INTERRELATED TO OTHER BLOCKS
Worker	N	Y	All	None

BLOCK #	TITLE	MANDATORY ENTRY	MAX. LENGTH	ALPHA OR NUMERIC
57	Spenddown Indicator	N/A	1	Alpha

The system enters an S here when the AFDC/U- or SSI-Related case has a spenddown. If the spenddown is met, the system removes the S. Cases which receive nursing care or reside in ICF/MR facilities show an S here when Block 67 is greater than $0.

ENTERED BY	FORCES RECALCULATION	AUTO REMOVED	PROGRAMS	INTERRELATED TO OTHER BLOCKS
System	N/A	Y	AFDC/U- and SSI-Related Medicaid	58, 80

BLOCK #	TITLE	MANDATORY ENTRY	MAX. LENGTH	ALPHA OR NUMERIC
58	Current Spenddown Amount	N/A	5	Numeric

For cases receiving nursing care services or residing in an ICF/MR, the amount here is the same amount found in Blocks 67 and 80. The amount changes only when the Worker changes Block 67 or the post-eligibility amount is recomputed.

For other cases, this is the system-determined current spenddown amount. Upon entry of a spenddown case this Block equals the amount in Block 80. Amounts entered in a WESDN transaction are subtracted from this amount, while Block 80 remains constant. The relationship between Blocks 58 and 80 is as follows:

- When Blocks 80 and 58 are greater than 0, the case has not met spenddown.
- When Block 80 is greater than 0, but Block 58 equals 0, either of the following is true
  - When Block 48 is equal to 0, the AFDC/U- or SSI-Related case has met spenddown.
  - When Block 48 is greater than 0, the case is a nursing care or ICF/MR case. The amount, which would normally be in this Block, is moved to Block 80.
- When Blocks 80 and 58 equal 0, the case is not a spenddown case.

ENTERED BY	FORCES RECALCULATION	AUTO REMOVED	PROGRAMS	INTERRELATED TO OTHER BLOCKS
System	N/A	Y	AFDC/U- and SSI-Related Medicaid	57,80

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
67	LTC Spenddown	N	5	Numeric

When a resident of a nursing care or ICF/MR facility must meet a spenddown as part of his contribution toward the cost of his care, the amount of such spenddown, is entered here. The amount entered here is automatically moved to Blocks 58 and 80.

ENTERED BY	FORCES RECALCULATION	AUTO REMOVED	PROGRAMS	INTERRELATED TO OTHER BLOCKS
Worker	Y	N	NF and ICF/MR Residents in Medically Needy Cases	69, 70, 71, 78, 79, 51, 58, 80, 48

BLOCK #	TITLE	MANDATORY ENTRY	MAX. LENGTH	ALPHA OR NUMERIC
68	Disposition Code	Y- Applications	1	Numeric

Enter the code which indicates the action taken on the application:

1: NEWAP
2: REOPN
3: NEWDN, DENIL
4: NEWWD, WITDR

ENTERED BY	FORCES RECALCULATION	AUTO REMOVED	PROGRAMS	INTERRELATED TO OTHER BLOCKS
Worker	N	Y	All	None

BLOCK #	TITLE	MANDATORY ENTRY	MAX. LENGTH	ALPHA OR NUMERIC
69	Community Spouse Maintenance Allowance (CSMA)	N	4	Numeric

The amount of the CSMA which is deducted from income in post-eligibility calculations is coded here.

ENTERED BY	FORCES RECALCULATION	AUTO REMOVED	PROGRAMS	INTERRELATED TO OTHER BLOCKS
Worker	Y	N	NF and ICF/MR Residents in Medically Needy Cases	67, 70, 71, 78, 79, 51, 48, 47

BLOCK #	TITLE	MANDATORY ENTRY	MAX. LENGTH	ALPHA OR NUMERIC
70	Family Maintenance Allowance (FMA)	N	4	Numeric

The amount of the FMA which is deducted from income in post-eligibility calculations is coded here.

ENTERED BY	FORCES RECALCULATION	AUTO REMOVED	PROGRAMS	INTERRELATED TO OTHER BLOCKS
Worker	Y	N	NF and ICF/MR Residents in Medically Needy Cases	67, 69, 71, 78, 79, 51, 48, 47

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
72	Worker ID Number	Y	2	Numeric

Each transaction must show the ID number of the Worker who takes the case action.

ENTERED BY	FORCES RECALCULATION	AUTO REMOVED	PROGRAMS	INTERRELATED TO OTHER BLOCKS
Worker	N	N	All	None

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

The system enters the amount that the client must contribute to his cost of care in addition to his spenddown amount here. This amount, plus the spenddown amount, is the client's total contribution which is placed in Block 51.

ENTERED BY	FORCES RECALCULATION	AUTO REMOVED	PROGRAMS	INTERRELATED TO OTHER BLOCKS
System	N	N	NF, ICF/MR	67, 71

BLOCK #	TITLE	MANDATORY ENTRY	MAX. LENGTH	ALPHA OR NUMERIC
79	Personal Needs Allowance	N	3	Numeric
The amount of the client's personal needs allowance is coded here for use in post-eligibility calculations.				
ENTERED BY	FORCES RECALCULATION	AUTO REMOVED	PROGRAMS	INTERRELATED TO OTHER BLOCKS
Worker	Y	N	NF, ICF/MR	67, 69, 70, 71, 78, 51, 48, 47

BLOCK #	TITLE	MANDATORY ENTRY	MAX. LENGTH	ALPHA OR NUMERIC
80	Original Spenddown Amount	N/A	5	Numeric

Note: For the relationship between Blocks 80 and 58, see Block 58.

For nursing care and ICF/MR cases, the amount entered in Block 67 is automatically moved to this Block. This amount is the same as the Block 58 amount.

For all others, this shows the spenddown amount of the case, as of entry into the system. This amount remains constant until the case is closed.

ENTERED BY	FORCES RECALCULATION	AUTO REMOVED	PROGRAMS	INTERRELATED TO OTHER BLOCKS
System	N/A	Y	AFDC/U- and SSI-Related Medicaid	57, 58

- 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 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.

Step 2: The amount of the Personal Needs Allowance coded in Block 79 is subtracted form the Step 1 amount.

Step 3: The amount of the CSMA coded in Block 69 is subtracted from the Step 2 amount.

Step 4: The amount of the FMA coded in Block 70 is subtracted from the Step 3 amount.

Step 5: When Block 47=1 and Blocks 69 and 70=0, $175 is subtracted from the Step 4 amount.

Step 6: The amount of non-reimbursable medical expenses in Block 71 is subtracted from the Step 5 amount.

Step 7: The client's spenddown amount, if any, in Block 67 is subtracted from the Step 6 amount.

Step 8: The remainder is the client's resource amount. The system places this amount in Block 78.

Step 9: The client's total contribution toward his cost of care is determined as follows:

- The amount in Block 78 is added to the amount in Block 67.

- The result of the above addition is placed in Block 51.

Step 10: The Department pays the difference between the cost of the nursing or ICF/MR care, determined by using the average Medicaid rate for each facility, and the client's contribution determined in Step 9. If the client's total contribution exceeds the cost of care, he is ineligible for nursing or ICF/MR care services.

D. QMB

The second prefix of the case is A or D. Steps 1 through 6 are the same as for SSI-Related Medicaid. See item B, above.

Step 7: The remaining amount is compared to 100% FPL for the number of people coded in Block 36 and is entered in Block 51 as the countable income for the case.

Step 8: If the amount in Block 51 is equal to or less than the appropriate 100% FPL amount, the case is eligible as a QMB. The system takes the following actions

- The case is assigned a Q as the first case prefix letter, based on the benefit code of QB in Block 11 and/or 12.
- Beginning and ending dates of eligibility are entered in Blocks 9 and 10.
- A medical card is issued beginning the following month.

Step 9: If the amount in Block 51 is greater than the appropriate 100% FPL, the system responds with an error message indicating the case is ineligible as a QMB.

E. SLIMB

SLIMB eligibility is determined the same way it is for QMB, with the following exceptions:

- Eligibility is determined based on 120% FPL.
- The case is assigned an S as the first case prefix letter, based on the benefit code of SB in Block 11 and/or 12.
- No medical card is produced, even when the case is eligible. See Chapter 16.

DUE TO CHANGES MADE IN

IM MANUAL CHANGE

NUMBER 4,

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CHAPTER 23

IS OBSOLETE.

LTC DESK REDETERMINATION

Case Name _____ **Name of Facility** _____ **Case No.** _____

A. INCOME AND DEDUCTIONS

(Items To Be Reviewed)	Action Required		Type of Action Required	Results of Follow-Up	Date Follow-Up Completed
	YES	NO			
1. Follow-up on previous identified benefits - current?					
2. CSMA or FMA					
3. Recent increase in RSDI, VA, etc.					
4. Other income					
Correct income amount $ _____ **Change ?** **YES** ( ) **NO** ( )					

B. ASSETS

(Items To Be Reviewed)	Action Required		Type of Action Required	Results of Follow-Up	Date Follow-Up Completed
	YES	NO			
1. Bank Accounts					
2. Accumulated personal expense allowance					
3. Homestead property					
4. Other assets					
Value of Assets $ _____ **Change ?** **YES** ( ) **NO** ( ) **Spousal Share** $ _____					

C. OTHER

(Items To Be Reviewed)	Action Required		Type of Action Required	Results of Follow-Up	Date Follow-Up Completed
	YES	NO			
1. Disability					
2. Blindness					
3. Nursing Facility Codes					

D. Potential Resources Identified

TYPE	Action Required		TYPE ACTION TAKEN
	YES	NO	
1. Medicare Part A			
2. Medicare Part B			
3. RSDI			
4. SSI			
5. Black Lung			
6. VA			
7. Other			

E. Recording and Data System Action

	Case No.	Date Transmitted
	Data System Entries and Term Response	
Memo to LTC Unit Indicated - Yes ( ) No ( )		
If Yes, date mailed: _____		
Contents of Memo:		

Date

Worker Signature