IBM Cúram Social Program Management
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*Cúram Income Support for Medical
Assistance Long Term Care Guide*

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> **Note**
>
> Before using this information and the product it supports, read the information in "Notices" on page 25

Contents

Chapter 1. Cúram Income Support for Medical Assistance Long Term Care Guide

Cúram Long Term Care Medical Assistance consists of three medical assistance coverage types that provide coverage for individuals who require institutional care over an extended period. Long-term care refers to the medical, social, personal care, and supportive services that are needed by people who lose some capacity for self-care because of old age or a chronic condition.

Introduction

Document Purpose

The purpose of this document is to provide a business level overview of the Long Term Care Medical Assistance program and the implementation of this coverage type within Cúram Income Support for Medical Assistance.

Audience

This document is intended for anyone interested in understanding the Cúram implementation of the Long Term Care Medical Assistance Program. It is intended for its readers to obtain a business level understanding of the program, of the specific evidence recorded in the system for the program, the activation of that evidence, and the creation and management of Long Term Care case processing.

Available Documentation

Supporting documentation relating to Medical Assistance and associated programs, can be found in the Business Analysts guide titled `Cúram Income Support for Medical Assistance Program Guide`. Caseworkers may also find the business guides for other Medical Assistance programs useful. For Spend Down, see the `Cúram Income Support for Medical Assistance Spend Down Guide`. For Children's Health Insurance Program, see `Cúram Income Support for Medical Assistance Children's Health Insurance Program Guide`.

Long Term Care Medical Assistance Overview

Introduction

This section contains an overview of Long Term Care, a list of the major differences between LTC and the other coverage types, and a listing of the changes to LTC coverage type with Cúram Express Rules.

About Long Term Care Medical Assistance

Cúram Long Term Care Medical Assistance consists of three Medical Assistance coverage types that provide coverage for individuals who require an institutional level of care over an extended period of time. Long Term Care refers to the medical, social, personal care, and supportive services needed by people who have lost some capacity for self-care because of old age or a chronic illness or a condition. This definition generally excludes medical care for acute conditions; however, post acute care, such as skilled nursing care and home health care, is often classified as long-term care.

To qualify for LTC:

Long Term Care may be received in a medical institution or, for those for whom it is possible to receive the same level of medical care at home, on a home and community based services waiver program (HCBS).

There are many different Long Term Care waiver programs covered in different states, the most common being Elderly, Physical Disabilities, Mental Retardation/Developmental Disabilities (MR/DD) and Brain Injury. The term 'institutionalized individual' refers to those on HCBS waiver programs as well as those physically in medical or nursing home institutions.

To qualify for LTC:

- The individual must be institutionalized AND
- The individual members must satisfy the non financial AND
- The household must satisfy level of care AND
- The household must satisfy the 30 consecutive day requirements AND
- The individual must be categorically eligible AND
- The individual must not have an expensive home AND
- The individual must not be subject to an invalid resource transfer sanction AND
- The individual must satisfy the Resource Test AND
- The individual must satisfy the applicable Income Test

Differences with Other Coverage Types

The Cúram Long Term Care program is more complex than other coverage types. The differences include:

- Three different coverage types
- Each coverage type has five different ways with which to pass to be eligible
- Post eligibility cost of care
- Invalid transfer penalties and sanctions
- Spousal impoverishment resource assessment

Coverage Types

Because there is such a variety in how states implement LTC, there are three different coverage types which implement three different income tests. These types are:

- Long Term Care - The income test checks for less than 300% of SSI federal benefit rate.
- Medically Needy Long Term Care - The income test checks for less than the average facility rate or less than the average facility rate minus deductions.
- Medically Needy Long Term Care with Spend Down - The income test checks for over 300% of the SSI federal benefit rate.

It is not expected that an agency would implement all three coverage types. The Spend Down coverage type uses the common Spend Down Processing. All rules other than income test are the same between the coverage types. The cascade hierarchy is from Long Term Care to Medically Needy Long Term Care to Medically Needy Long Term Care with Spend Down.

Waivers

Each coverage type has five different ways with which to pass to be eligible (institutionalized and four waivers: Elderly, Physical Disabilities, Mental Retardation/Developmental Disabilities, and Brain Injury). An individual may pass only one of the five. The results display on the Household Tab. If the individual passes a specific waiver, a Pass will display along with the waiver name. If the individual is eligible and does not pass for a waiver type, then the individual passed for institutionalized.

The evidence used to determine if an individual is eligible for a waiver includes: Disability, Level of Care, and Medical Institution, as well as individual's age. See the Waivers section in this guide to see the rules for the specific waivers.

Post Eligible Cost of Care Calculation

Unlike other Medical Assistance coverage types, the full liability for nursing home or waiver care is not usually completely incurred by the Medical Assistance agency - the institutionalized individual must usually contribute to their cost of care. The amount paid by the institutionalized individual is based on their total monthly income with some deductions made for personal needs, family dependents, shelter allowances, and income.

Transfer of Resources Assessment

In Long Term Care, an individual must declare information about resources they, their spouse or any individual acting on their behalf have transferred to another individual within a specified period of time prior to application, known as the 'look-back period'. This information is required to determine if the individual transferred the resource specifically in order to qualify for Long Term Care Medical Assistance, in which case they would be ineligible for a period related to the invalid transfer amount. The look-back period is a constant time-frame of 60 months.

Spousal Impoverishment Resource Assessment

For an individual with a community spouse, special provisions called Spousal Impoverishment provisions apply to individuals who became institutionalized after 1989. The purpose of this provision is to allow the community spouse to keep some of the institutionalized individual's resources as determined on a specific date (assessment date). Under spousal impoverishment provisions, an institutionalized individual may receive Long Term Care Medical Assistance if he or she agrees to bring his or her resources below the resource limit by transferring them to his or her spouse within a specified time known as the 'protected period'.

Changes to LTC Coverage Types with Cúram Express Rules

The major changes to the LTC coverage type with Cúram Express Rules are:

- As stated above, there are now three coverage types for Long Term Care.
- Special processing at evidence activation has been removed.
- For invalid resource transfers, a period of ineligibility is created at application.
- Invalid resource transfers display as part of eligibility decisions.
- Spousal Impoverishment details display as part of the eligibility decisions in Resources.
- Expensive home rules have been added and display as part of eligibility decisions in Household.

Special Processing at Evidence Activation

Previously the Long Term Care program had system processing functionality that was triggered when evidence is activated and before eligibility was checked. This functionality checked whether or not the evidence suggested that the institutionalized individual should be sanctioned for transferring assets specifically in order to qualify for Long Term Care coverage. This processing has been removed. The concern was that if initial evidence entered was incorrect, it was not easy to reverse or correct a sanction once created. Now invalid resource transfers are created by the eligibility rules which can modify the sanction/period of ineligibility as necessary.

Invalid Resource Transfers

Previously only sanctions were created for invalid resource transfers. Now a period of ineligibility is created at application and a sanction is created for an ongoing LTC case. The functionality between the two penalty types is the same; the individual with a sanction or invalid resource transfer is ineligible for LTC.

The rules for the LTC coverage types include determination of invalid resource transfers based on transfer to individual evidence. Invalid resource transfer displays in the Compliance section of LTC eligibility decisions.

Spousal Impoverishment

Spousal Impoverishment details display as part of the eligibility decisions rather than waiting until after the product delivery is activated. When transfers occur between spouses, this can be seen on reassessment in eligibility decisions.

Expensive Home

Expensive home rules determine if the individual has an equity interest in a home not valued at the state defined limit of $525,000 or if the individual meets an exception. The exception is if certain individuals are living in the home.

Eligibility Determination and Product Delivery Creation

Introduction

This chapter covers eligibility rules at a high level as well as a description of viewing eligibility decisions.

Certification Requirements

Institutionalized individuals who are eligible for, or in receipt of standard medical assistance services under one of the existing coverage types meet the categorical eligibility criteria for nursing home or home and community based care under a Long Term Care program. Institutionalized individuals who are currently not in receipt of or eligible for another Medical Assistance coverage type, but who are aged, blind or disabled according to SSA disability criteria also meet the categorical eligibility criteria. Level of Care certification must be received, and it must be current, must be completed by a qualified physician within a specified time period prior to application for Long Term Care, and must be re-evaluated on a regular basis as specified by the state.

Financial Unit

The institutionalized individuals are categorized into an appropriate financial unit according to whether or not they are a:

- Single institutionalized individual
- Child who is blind or disabled
- Married couple with an institutionalized spouse
- Married couple with a community spouse

These same financial units are used for both income and resource processing.

Declaration of Resources

In Long term Care, an individual must declare information about resources, to determine if:

- The individual passes resources limits
- Any transfer to individual's incurred an uncompensated value
- There is a community spouse, for the resource assessment

Resource Limits

All applicants for Long Term Care Medical Assistance must pass a resource test. This resource test determines whether or not an individual's resources are under the required resource limits.

In the case of a blind or disabled institutionalized child, the resources of the parents are deemed to the child. The child must then qualify under specific Long Term Care resource limits (usually $2000). A single institutionalized individual must also qualify under the same resource limits. Each member of a couple, where both spouses are institutionalized, is treated separately. The income of only the institutionalized

spouse is counted against the income limit but the resources of both spouses are counted together and compared to LTC couple resource limit.

If the financial unit determined is 'institutionalized individual with community spouse', and the individual was institutionalized before October 1989, the system executes the same rules as for a single institutionalized individual. If the individual was institutionalized on or after October 1989, spousal impoverishment processing is performed. Spousal Impoverishment calculations are performed by rules. The system determines the value of all countable assets belonging to the institutionalized individual and the community spouse on a specific date called the Assessment Date. The rules determine an appropriate spousal share for each spouse. Generally the spousal share is half the couple's resources on the assessment date; however, there are limits and if the spousal share is below the minimum or above the maximum, the spouse's share may be increased or decreased. This is called the Community Spouse Share. If the institutionalized individual's resources are less than the resource limit, then the individual is eligible and not protected period is required. If the institutionalized individual's resources are over the limit (usually $2000), the resources are compared to the resource limit plus the Community Spouse Share.

Invalid Resource Transfers

If there is an existing invalid resource transfer the individual is not eligible until the end of the period of ineligibility or sanction. If the rules determine that evidence contains an invalid resource transfer within the look-back period, a period of ineligibility or sanction is created.

Income Limits

In addition to passing a resource test, all applicants for Long Term Care Medical Assistance must pass an income test. The income test varies based on the Long Term Care coverage type.

Individual Contributions

The rules calculate deductions to be used to determine the individual's contribution toward their cost of care. This is the monthly amount an individual is obligated to pay to a medical institution, nursing home, or HCB waiver services provider for their care. The individual's contribution towards their cost of care for the month is determined as gross monthly income less allowable deductions/allowances. The allowances/ deductions specific to these calculations are the Earned Income Deduction, the Personal Needs Allowance, the Community Spouse Allowance, the Family Dependent Allowance, the Medical Expense Deduction, the Home Maintenance Allowance and the Legal Guardian Expense Deduction. The remaining amount after the deductions/allowances are applied is the individual's contribution towards their cost of care for the month. This amount is displayed as part of the eligibility decision.

Check Eligibility for Medical Assistance Programs including Long Term Care

If a client applies for Medical Assistance, the system checks if the client is eligible for a number of coverage types within the program. If the client is eligible for a coverage type at the top of the cascade, the lower coverage types are not checked. If the client fails a higher coverage type the system checks the next coverage type below, and keeps checking until the rules find a coverage type the client passes. The Long Term Care (SIL) coverage type (and succeeding coverage types) runs in parallel with QMB (then SLMB) cascade and LIFC/ABD cascade (and succeeding coverage types). If the individual is not eligible for the Long Term Care coverage type, the Medically Needy Long Term Care coverage type is checked. Then if not eligible, the Medically Needy Long Term Care with Spend Down coverage type is checked. Each is checked through the process described in this section. For more information on the cascade, see the Overview chapter of the Cúram Income Support for Medical Assistance Program Guide.

When processing the Long Term Care rules, the system will then identify the appropriate financial resource unit for any eligible individual(s). In all cases, the rules will determine whether the individual passes the non financial requirements, categorical, level of care, and 30 consecutive day requirements, expensive home, and whether there is an existing period of ineligibility or sanction or new invalid resource transfer. The system will then run through the income and resource rules for the appropriate financial unit. If required, the rules check the post-eligibility deductions.

Rules calculate the amount of assets to be transferred and this amount is displayed as part of the eligibility decision. The institutionalized individual must agree to transfer the required amount of resources within a specified period defined by the state, known as the protected period. The begin date of the protected period is the date of eligibility.

If an institutionalized individual fails Long Term Care eligibility because of excess income, the individual may be eligible for Medically Needy Long Term Care. If the individual fails the income test in this coverage type, the individual may be eligible for Medically Needy Long Term Care with Spend Down.

View Eligibility Decisions for Medical Assistance Programs including Long Term Care

Upon completion of the check Medical Assistance rules, the eligibility decisions display. The individual may be eligible for one of the three Long Term Care coverage types.

Cost of care refers to the requirement for the institutionalized individual to contribute to their own cost of care. The amount of income that an individual must pay towards their cost of care is appended to the Summary and Income details on the Medical Assistance eligibility decisions. For income, the details of the Earned Income Deduction, the Personal Needs Allowance, the Community Spouse Allowance, the Family Dependent Allowance, the Medical Expense Deduction, the Home Maintenance Allowance and the Legal Guardian Expense Deduction display.

Spousal Impoverishment results are also appended to Resource details on Medical Assistance results. The details of the two resource tests, the assessment details including each client's assessed resources, total amount to transfer, remaining amount to transfer display, and protected period dates display.

Note that the caseworker can also view a list of ineligible decisions from the Medical eligibility decisions. For example if ineligible for the Long Term Care coverage type, but eligible for Medically Needy Long Term Care, the Long Term Care coverage type displays in ineligible decisions.

Create Long Term Care Medical Assistance Product Delivery

Caseworkers can create Long Term Care product delivery cases for household members who are eligible for Long Term Care coverage types as displayed in Medical Assistance eligibility decisions. The selection of a Long Term Care Medical Assistance coverage type may have implications for other members of the household on other Medical Assistance coverage type. For example, a Household Member who is currently in receipt of LIFC, but who has left the home and entered a medical institution (not a HCBS Waiver) for Long Term Care is no longer considered to be resident in the home and is therefore ineligible for LIFC. If there is no other caretaker relative in the home, LIFC will be terminated for all members of the household. Similarly, selecting a Long Term Care Medical Assistance coverage type where a transfer of assets is required assumes that the institutionalized individual has agreed to transfer assets to their spouse. In certain situations, this transfer of assets may render the community spouse ineligible for an existing Medical Assistance program. It is up to the caseworker to discuss the options and their implications with the household member(s) concerned.

When the client applies for Medical Assistance and is found eligible for a Long Term Care coverage type, after all the evidence is verified and activated, the caseworker authorizes the LTC coverage type. When the caseworker confirms that they wish to create the selected Medical Assistance program the product delivery can be viewed. In the case of Long Term Care coverage types, this assumes that the household member concerned is willing to accept any existing conditions of eligibility, i.e. cost of care. Long Term Medical Assistance functionality uses existing product delivery functionality within the product.

Long Term Care Rules

Introduction

This chapter outlines the rules for determining eligibility for the Long Term Care program. The income rules for each of the three coverage types are included.

To qualify for LTC:

- The individual must be institutionalized AND
- The individual members must satisfy the non financial requirements AND
- The household must satisfy level of care AND
- The household must satisfy the 30 consecutive day requirements AND
- The individual must be categorically eligible AND
- The individual must not have an expensive home AND
- The individual must not be subject to an invalid resource transfer sanction AND
- The individual must satisfy the Resource Test AND
- The individual must satisfy the applicable Income Test

Institutionalized

The individual must have a Medical Institution record.

Level of Care

The individual must meet one of the following levels of care:

- Intermediate or Skilled Nursing Care OR Intermediate Care for the Mentally Retarded OR Hospital Level of Care OR IMD AND
- Level of Care must be certified by a physician or recognized authority AND
- The LOC certification is valid

Non Financial Requirements

The child must satisfy the standard non financial requirements rules for Citizenship, SSN and Residency.

See Non Financial Requirements in the Common Rules - Non Financial Requirements chapter in the `Cúram Income Support for Medical Assistance Program Guide`.

30-Consecutive Day Requirement

To qualify for Medicaid as an Institutionalized patient an individual must meet one of the following conditions for at least 30 consecutive days (unless there is an Exception):

- Reside in a Title XIX certified nursing facility OR
- Be an inpatient in a hospital OR
- Participate in a Home and Community Based Services Waiver program

Exceptions to the 30-Consecutive Day Requirement

An individual is not required to satisfy the 30 consecutive day rule in either of the following conditions:

- The individual was in receipt of Medicaid when entering the institution or home and community based program OR
- The individual dies before the 30 days are met OR
- A disabled child is a resident of a medical institution if the stay is expected to exceed 30 days, even if it is temporary.

Disabled Child

- If a baby, meeting disability criteria, is born in a hospital and is subsequently a resident of that hospital throughout the remainder of that month, the baby is considered to be a resident of the hospital throughout the month of his/her birth OR
- An infant who is born disabled, and who remains in the hospital for an extended time after birth is a resident of the medical institution from the date of birth

Special Considerations for 30 day rule

The 30 consecutive day rules is still satisfied under the following conditions:

- If the individual is temporarily absent for not more than 14 full consecutive days providing the person remains under the jurisdiction of the institution OR
- If the individual moves from a Medical Facility to HCBS - once they enter the waiver within 10 days of discharge from the nursing home.

Categorically Eligible

To qualify as categorically eligible:

- A person currently receiving any Medicaid coverage type (apart from a cost sharing programs, excluding cost Sharing, Medically Needy with Spend Down, Refugee or Emergency, and Cancer) is categorically eligible OR
- A person who meets the criteria for one of the following categories of coverage Aged, Blind, Disabled OR
- A person who meets the criteria for one of the following Waivers: Brain Injury, MRDD, Physical Disability, Elderly (See Waivers section in this chapter)

ABD Special Conditions

To qualify under the Medicaid Program in one of the ABD LTC related categories a person must qualify under one of the following conditions:

- To qualify under the Age Program an individual must be aged 65 or older OR
- To qualify under the Disabled or Blind Medicaid Program, a person must: meet the Social Security criteria for blindness or disability and be certified as such either by the SSA or by the Disability Determination Services (DDS) or equivalent agency in the State OR
- To qualify as a Deemed SSI Recipient the individual's eligibility under the Protected SSI group allows them to qualify as disabled or blind.

Expensive Home

The LTC Individual must not own a home over the home equity resource limit <$525,000>. Or must meet one of the three options to meet the expensive home exception:

- The LTC individual has a spouse and spouse lives in the home OR
- The LTC individual has a child who is under age 21 and the child lives in the home OR
- LTC individual has a child and child lives in the home AND
- Child is blind OR child is totally and permanently disabled

Waivers

Applicant must meet the eligibility criteria for one of the waiver groups:

1. Brain Injury OR
2. MR/DD OR
3. Physical Disability OR
4. Elderly

Brain Injury

Applicants must meet all the following criteria:

- Age not less than the TBI minimum age requirement (18) AND
- Age less than TBI maximum age requirement (65) AND
- Certified as having a traumatic brain injury OR acquired brain injury AND
- NOT a TBI Exception AND

- Qualify for a Nursing Home Level of Care

MR/DD

Applicants must meet all the following criteria:

- Mental retardation must be evident before MR Age (18) OR
- Developmental Disability must be evident before DD Age (22) AND
- Qualify for ICF/MR Level of Care AND
- Be certified as Developmentally Disabled OR
- Be certified as Mentally Retarded

Physical Disability

Applicants must meet all the following criteria:

- Age not less than the Physical Disability Minimum age requirement (18) AND
- Qualify for Nursing Home Level of Care AND
- Have medically certified physical disability

Elderly

Applicants must meet all the following criteria:

- Be Aged not less than Elderly Age (65) AND
- Qualify for Nursing Home Level of Care

Transfer of Assets

Individuals are ineligible for LTC if there is a transfer of resources for less than fair market value for a length of time calculated as follows:

1. Individual is not eligible for LTC during sanction period
2. For a time period that hasn't been looked at yet AND
3. For the people that do NOT have hardship AND
4. For the included time period (look-back period)
5. Determine if there are any invalid transfers that fall in the look-back period AND
6. For every countable asset transferred by the following individuals:
7. Determine if the asset is countable or excluded
8. If asset is countable determine whether asset transfer is allowed under transfer of assets rules
9. Sum the uncompensated values
10. Calculate the ineligibility period
11. If there is uncompensated value, determine Ineligibility or Sanction Period
12. Determine Period of Ineligibility or Sanction Start/End Date

Existing Eligibility Period

On application check if a period of ineligibility exists for a household and period of ineligibility has not expired:

- If a period of ineligibility has expired, determine if an invalid resource transfer exists
- If a period of ineligibility has not expired, household is ineligible

Invalid Resource Period Determination

Undue Hardship

- The client has exhausted all reasonable legal means to regain possession of the transferred asset AND
- Without Medicaid coverage for institutional or Home and Community-Based care, the client will not be able to get the medical care needed AND
- The client is at risk of death or permanent disability without that care

Transfer of any asset on or after February 8 2006

The look-back date for transfers made on or after February 8, 2006 is 60 months before the later of the date the individual is institutionalized and applies for Medicaid.

Look-Back Period

The asset transfer penalty applies to any transfer for less than fair market value made during a period preceding or following a request for long-term care services. The look-back period is determined as follows:

- The look-back date for transfers made on or after February 8, 2006 is 60 months before the later of the date the individual is institutionalized and the date applies for Medicaid.

Transfer to Individual

Determine the household members to look at a transfer to individual. (See Penalty for Resources Transferred by the following Individuals.)

Determine if there are any invalid resource transfers in the look-back period for the specified individuals:

1. Determine if the asset is countable or excluded
2. For countable assets where the transfer occurred in the look-back period, determine if an Invalid Resource Transfer Exception applies
3. If an exception doesn't apply, determine the uncompensated value for each transfer.
4. Check if Uncompensated Value is greater than zero.

Penalty for Resources Transferred by the following Individuals

- Determine resource transfers for the individual or anyone acting on the individual's behalf AND
- Determine resource transfer's for the individual's spouse or anyone acting on their behalf

Transfer of Resource Penalty Exception

Do not impose penalty on individuals who transfer resources in one of the following cases:

Allowable Transfer

The following transfers are allowed without penalty:

- Transfer of a home or any other asset to the spouse, or to another for the sole benefit of the spouse OR
- Transfer of any asset to a blind or disabled son or daughter or to another for the sole benefit of a blind or disabled son or daughter OR
- Transfer of any asset to a blind or disabled son or daughter OR
- Transfer to a trust established for the sole benefit of a blind or disabled son or daughter OR
- Transfer of a home to a son or daughter under 21 years of age OR
- Transfer to a trust established for the sole benefit of an individual who is blind or disabled and who is under age 65 OR
- Transfer of a home to a sibling who has an equity interest in the home and who has lived in the home for at least 1 year immediately preceding the client's entry into a medical institution.

- Transfer of a home to a son or a daughter who has lived in the home and provided care to the client which permitted the individual remain at home rather than be institutionalized or be on a waiver and has done so for at least 2 years prior to the individual's entry into the medical institution.
- Meets Proof that Medicaid was not the reason for the transfer (see the section Medicaid not the Reason for Transfer) OR
- Trusts established before February 8, 2006

Sole benefit means that no other individual can benefit from the transfer

Medicaid not the Reason for Transfer

In order for a client to prove that Medicaid was not a reason for the transfer, the client must provide documentation establishing that there were unexpected circumstances that happened after the transfer occurred:

- The client suddenly, unexpectedly, became disabled AFTER the transfer OR
- The client learned that he or she had a disabling condition AFTER the transfer OR
- The assets were transferred to a religious order by a member of that order in accordance with a vow of poverty

Length of Penalty

- The sanction period will be the number of months computed by dividing the uncompensated, equity value of the transferred assets by the nursing home private-pay rate in effect at the time of the transfer. The client will be ineligible for the number of months computed. There is no maximum penalty period.
- Penalty Period equals the full months and any partial months calculated as follows:
  - Total the uncompensated amount of all transfers
  - Divide by the average private pay rate
  - Round down to 2 decimal places
  - To determine the number of days for the fractional amount transferred, multiply the decimal amount by 30. Drop any partial day.

Penalty Period Start Date

- The penalty period begins on the date that the person is an institutionalized person, has applied for Medicaid, and would otherwise be eligible for Medicaid for nursing home or long-term care services except for the penalty period OR
- If the transfer occurs after the individual is eligible, the penalty begin date is the first of next month AND
- Penalty periods are applied consecutively and not concurrently

Financial Unit

There are four financial units for LTC depending on the household configuration. Rules are different for these different unts.

- Disabled Child - Child who is blind or disabled OR
- Single Institutionalized Individual
- Married and Institutionalized Couple - Married couple where both individuals institutionalized (or waiver) OR
- Institutionalized with Community Spouse - Married couple where one is institutionalized (or waiver) and other is community spouse

Resources Rules

Resource rules vary by financial unit type.

Single Institutionalized Individual

1. Count only the countable resources of the individual to determine eligibility

2. Calculate individual's countable resources AND

3. Compare the resources to the resource limit, if it is equal to or less than the resource limit the individual is eligible

Institutionalized Blind or Disabled Child

- If an un emancipated blind or disabled individual under 18 years of age, lives with at least one parent and then enters an institution, the resources of the parent(s) are deemed to the child.

- If an un emancipated blind or disabled individual under 21 years of age and in school lives with at least one parent and then enters an institution, the resources of the parent(s) are deemed to the child. If emancipated use rules for single institutionalized individual

- To determine the amount of resources deemed to the individual

  - Calculate institutionalized child's countable resources AND

  - If parent(s) are living with the institutionalized child, carry out parent to child deeming AND

  - Add total deemed resources from the parent(s), if any, to the individual's total countable resources to determine the total countable resources for the eligible child

- The institutionalized child is resource eligible for institutional care Medicaid if countable resources do not exceed the asset limit ($2,000).

Disabled Child Exception

- If a baby, meeting disability criteria, is born in a hospital and is subsequently a resident of that hospital throughout the remainder of that month, the baby is considered to be a resident of the hospital throughout the month of his/her birth and no parental resources are deemed OR

- An infant who is born disabled, and who remains in the hospital for an extended time after birth is a resident of the medical institution from the date of birth and no parental resource are deemed.

Married couple both institutionalized (or on a waiver)

1. Calculate eligible individual's countable resources AND

2. Total eligible spouse's countable resources AND

3. Combine the countable resources for the eligible individual and the eligible spouse AND

4. Compare the resources to the resource limit. If resources are equal to or less than the LTC Couple resource limit both individuals meet the resource test.

Married institutionalized individual with community spouse

Spousal Impoverishment is a term used to refer to an additional assessment provided to a couple when only one spouse resides in an institution and the other spouse is in the community, and when only one spouse is eligible for Home and Community Based Waiver services and the other is not. The purpose of the provision is to allow the community spouse to keep a share of the resources of the couple. The provision protects a person whose husband or wife goes into an institution or becomes eligible for waiver services from having to deplete all the couple's resources in order for the institutionalized or waiver spouse to qualify for Medicaid.

Assessment of assets is a process of dividing the value of all countable (non exempt) assets that belong to the institutionalized or waiver client and the client's spouse.

Last Entry Pre 01/10/1989

- Count only the countable assets in the client's name to determine eligibility (this includes joint assets).

- Compare the assets to the asset limit, if it is equal to or less than the asset limit the client is eligible

Last entry on or post 01/10/1989

Providing the client was married to the current spouse and the client was institutionalized for a period of 30 days or more the asset tests is based on the combined assets of the couple. The steps to calculate are as follows:

1. Calculate the date of assessment. It's the first of the month of institutionalization.
2. Calculate institutionalized individual's countable resources as on the date of assessment AND
3. Total community spouse's countable resources as on the date of assessment AND
4. Combine the countable resources for the institutionalized individual and the community spouse AND
5. DIVIDE the total assets by 2 to give the Spousal Share AND
6. Compare the Spousal Share to the Minimum Spousal Amount AND
7. If the Spousal Share is less than the Minimum Spousal Amount

    • The Spousal Share is the lesser of the total assets of the couple AND
    • the Minimum Spousal Amount

8. If the Spousal Share is greater than the Minimum Spousal Amount and less than the Maximum Spousal Amount

    • The Spousal Share is the total derived from step 5 above

9. If the Spousal Share is greater than the Maximum Spousal Amount

    • The Spousal Share is the Maximum Spousal Amount

10. Declare the Assessed Share of Assets (Spousal Share) for the Institutionalized Individual and Spouse.
11. If the remainder is LESS than the asset limit the client is eligible OR
12. If the institutionalized individual's countable resources exceeds the asset limit the client may be eligible if they agree to transfer assets to the spouse within a time frame OR

    • If the client's assets are NOT LESS than the asset limit, the client may receive Medicaid pending transfer of assets. The transfer to the community spouse can take place at any time but eligibility is not established until the resource share of the community spouse is equal to or below the spousal share after the transfer is made and the client's resources are at or below $2000. The client may receive Medicaid only if he agrees to bring his assets below the asset limit by transferring them to his spouse. The client must provide a statement expressing an agreement to transfer the appropriate amount of assets by the due date of the next review.

13. If the remainder exceeds asset limit and the client does not agree to transfer assets, the client is ineligible UNLESS he proves Undue Hardship

    Spousal impoverishment undue hardship may exist if:

    • Counting the spouse's assets as available to the institutionalized client causes the client to exceed the asset limit AND
    • The client's spouse refuses to make the assets available AND
    • Without Medicaid coverage for institutional care, the client will not be able to get the medical care needed AND
    • The client is at risk of death or permanent disability without institutional care.

Income Rules

Cúram Medical Assistance includes three income options which are implemented through three different coverage types:

• Long Term Care - The income test checks for less than 300% of SSI federal benefit rate.
• Medically Needy Long Term Care - The income test checks for less than the average facility rate or less than the average facility rate minus deductions.

- Medically Needy Long Term Care with Spend Down - The income test checks for over 300% of the SSI federal benefit rate.

Long Term Care Income Option

This is a special income level (SIL) test. The income test checks for less than 300% of SSI federal benefit rate.

These are the steps to follow when determining income eligibility for LTC related programs:

1. Determine the appropriate financial unit. (See the Financial Unit section in this chapter.)
2. For the financial unit determined, carry out the steps outlined for the Gross Income Test. Run the deductions. (See the Deductions section in this chapter.)
3. If the client fails the LTC Gross Income Test the client is ineligible for LTC.

Gross Income Test

Married Couple where Both Individuals Institutionalized

If both spouses are institutionalized, apply the following rules:

- Calculate the individual's countable gross unearned income
- Calculate the spouse's countable gross unearned income
- Combine the countable gross unearned income of the couple
- Calculate the individual's countable gross earned income from all sources (including self employment income)
- Calculate the spouse's countable gross earned income from all sources (including self employment income)
- Combine the countable gross earned income of the couple
- Add the countable gross unearned income and the countable gross earned income to determine the total gross countable income for the eligible couple
- Compare gross amount to state maximum allowable monthly income standard.
- Exception: If spouses are both institutionalized but ineligible when treated as a couple, treat each spouse as a single institutionalized individual

Single Institutionalized Individual

- Total the individual's countable gross unearned income
- Total the individual's countable gross earned income from all sources (including self employment income)
- Total the individual's countable gross earned and unearned income to give total gross income.
- Compare gross amount to state maximum allowable monthly income standard.

Married Couple where One is Institutionalized and Other is Community Spouse

- Calculate the individual's countable gross unearned income
- Calculate the individual's countable gross earned income from all sources (including self employment income)
- Add the countable gross unearned income and the countable gross earned income to determine the total gross countable income
- Compare gross amount to state maximum allowable monthly income standard.

Institutionalized Blind or Disabled Child

- If an un emancipated blind or disabled individual under 18 years of age, lives with at least one parent and then enters an institution, the resources of the parent(s) are deemed to the child for the month of eligibility.
- If an un emancipated blind or disabled individual under 21 years of age and in school lives with at least one parent and then enters an institution, the income of the parent(s) are deemed to the child for the month of eligibility.
- Calculate the child's countable gross unearned income
- Calculate the parent(s) countable gross unearned income
- Calculate the parent(s) countable gross earned income from all sources (including self employment income)
- Carry out the parent to child deeming process
- Add the total deemable income, if any, of the parent(s) to the eligible child's countable gross unearned income
- Calculate the child's countable gross earned income from all sources (including self employment income)
- Add the countable gross unearned income and the countable gross earned income to determine the total gross countable income for the eligible child
- Compare gross amount to state maximum allowable monthly income standard.

Disabled Child Exception

In the following cases, the child should be treated as a single institutionalized individual:

- If a baby, meeting disability criteria, is born in a hospital and is subsequently a resident of that hospital throughout the remainder of that month, the baby is considered to be a resident of the hospital throughout the month of his/her birth and no parental resources are deemed OR
- An infant who is born disabled, and who remains in the hospital for an extended time after birth is a resident of the medical institution from the date of birth and no parental resource are deemed.
- An emancipated child

Medically Needy Long Term Care Income Option

An individual can qualify under Medically Needy rules for LTC by applying deductions to their income and comparing the remainder to the LTC Reimbursement Rate.

The individual does not have a miller trust AND

These are the steps to follow when determining the individual's medically needy income eligibility:

1. Determine the appropriate financial unit
2. For the financial unit determined, carry out the steps outlined for the Gross Income Test
3. If the client's gross income is less than or equal to the LTC Reimbursement Rate then the client is eligible
4. If the client's gross income is more than the LTC Reimbursement Rate apply the Deductions (see Deductions section in this chapter)

Gross Income Test

Married Couple where Both Individuals Institutionalized

If both spouses are institutionalized, apply the following rules:

- Calculate the individual's countable gross unearned income
- Calculate the spouse's countable gross unearned income

- Combine the countable gross unearned income of the couple
- Calculate the individual's countable gross earned income from all sources (including self employment income)
- Calculate the spouse's countable gross earned income from all sources (including self employment income)
- Combine the countable gross earned income of the couple
- Add the countable gross unearned income and the countable gross earned income to determine the total gross countable income for the eligible couple
- Determine the facility's monthly LTC Reimbursement Rate
- Compare gross amount to monthly LTC Reimbursement Rate

Exception: If spouses are both institutionalized but ineligible when treated as a couple, treat each spouse as an single institutionalized individual

Single Institutionalized Individual

- Calculate the individual's countable gross unearned income
- Calculate the individual's countable gross earned income from all sources (including self employment income)
- Add the individual's countable gross earned and unearned income to give total gross income.
- Determine the facility's monthly LTC Reimbursement Rate
- Compare gross amount to monthly LTC Reimbursement Rate

Married Couple where One is Institutionalized and Other is Community Spouse

- Calculate the individual's countable gross unearned income
- Calculate the individual's countable gross earned income from all sources (including self employment income)
- Add the countable gross unearned income and the countable gross earned income to determine the total gross countable income
- Determine the facility's monthly LTC Reimbursement Rate
- Compare gross amount to monthly LTC Reimbursement Rate

Eligible before Deductions (cost of care to be determined at post eligibility)

- If the client's gross income is less than or equal to the LTC Reimbursement Rate then the client is eligible
- If the client's gross income is more than the LTC

Reimbursement Rate apply the Deductions as follows:

1. Determine the individual's gross unearned income AND
2. Determine the individual's gross earned income AND
3. If the individual's earned income is greater than zero, apply the Earned Income Deduction to earned income AND
4. Total the individual's unearned income and earned income to give gross income for the individual AND
5. Apply the Personal Needs Allowance (see the Personal Needs Allowance section in this chapter) AND Apply the Community Spouse Needs Allowance (see the Community Spouse Needs Allowance section in this chapter) AND
6. Apply the Family Dependent Allowance (see the Family Dependent Allowance section in this chapter) AND
7. Apply the Medical Expense Deduction (see the Medical Expense Deduction section in this chapter) AND

8. Apply the Home Maintenance Allowance (see the Home Maintenance Allowance section in this chapter) AND

9. Apply the Legal Guardian Expense Deduction (see the Legal Guardian Expense Deduction section in this chapter)

- If the remaining amount after deductions have been applied is less than or equal to the LTC Reimbursement Rate (monthly) then the client is eligible

- If the remaining amount after the deductions have been applied is more the projected LTC Reimbursement Rate (monthly) then the client is medically needy ineligible.

- The remaining amount after deductions have been applied is the individual's contribution towards cost of care for the month.

Institutionalized Blind or Disabled Child

- If an un emancipated blind or disabled individual under 18 years of age, lives with at least one parent and then enters an institution, the resources of the parent(s) are deemed to the child for the month of eligibility.

- If an un emancipated blind or disabled individual under 21 years of age and in school lives with at least one parent and then enters an institution, the income of the parent(s) are deemed to the child for the month of eligibility.

- Calculate the child's countable gross unearned income

- Calculate the parent(s) countable gross unearned income

- Calculate the parent(s) countable gross earned income from all sources (including self employment income)

- Carry out the parent to child deeming process (in the Adult - Common Income Rules chapter of this guide, see the Income Deeming section in the `Cúram Income Support for Medical Assistance Program Guide`)

- Add the total deemable income, if any, of the parent(s) to the eligible child's countable gross unearned income

- Calculate the child's countable gross earned income from all sources (including self employment income)

- Add the countable gross unearned income and the countable gross earned income to determine the total gross countable income for the eligible child

- Determine the facility's LTC Reimbursement Rate (monthly)

- Compare gross amount to monthly LTC Reimbursement rate.

Disabled Child Exception

In the following cases, the child should be treated as a single institutionalized individual:

- If a baby, meeting disability criteria, is born in a hospital and is subsequently a resident of that hospital throughout the remainder of that month, the baby is considered to be a resident of the hospital throughout the month of his/her birth and no parental resources are deemed OR

- An infant who is born disabled, and who remains in the hospital for an extended time after birth is a resident of the medical institution from the date of birth and no parental resource are deemed.

- An emancipated child

Medically Needy Long Term Care with Spend Down Income Option

The gross income test checks for over 300% of the SSI federal benefit rate plus additional rules below.

These are the steps to follow when determining income eligibility with Spend Down for LTC related programs:

1. Determine the appropriate financial unit. (See the Financial Unit section in this chapter)

2. Perform the income steps as defined in the Financial Unit Steps section below.

3. If the client's net income is less than or equal to the LTC Income Eligibility Standard (LTC IES) established by the state, the client is income eligible with no spend down amount.

4. If the client's net income is greater than the LTC IES established by the state, calculate the client's spend down liability.

5. If the spend down amount determined in 4 above is greater than zero, carry out the steps for LTC spend down

Income Test

The LTC Net Income Test is only carried out if the financial unit's gross income is above 300% SSI.

Institutionalized Blind or Disabled Child

- If an un emancipated blind or disabled individual under 18 years of age, lives with at least one parent and then enters an institution, the resources of the parent(s) are deemed to the child for the month of eligibility.
- If an un emancipated blind or disabled individual under 21 years of age and in school lives with at least one parent and then enters an institution, the income of the parent(s) are deemed to the child for the month of eligibility.
- Calculate the child's countable gross unearned income
- Calculate the parent(s) countable gross unearned income
- Calculate the parent(s) countable gross earned income from all sources (including self employment income)
- Carry out the parent to child deeming process
- Add the total deemable income, if any, of the parent(s) to the eligible child's countable gross unearned income
- Apply unearned income deductions to the child's countable gross unearned income to determine the countable net unearned income
- Calculate the child's countable gross earned income from all sources (including self employment income)
- Apply earned income deductions to the child's countable gross earned income to determine the net earned income:
- Add the countable net unearned income and the countable net earned income to determine the total net countable income for the eligible child
- Compare net countable income to the state defined Long Term Care Income Eligibility Standard.

Disabled Child Exception

In the following cases, the child should be treated as a single institutionalized individual:

- If a baby, meeting disability criteria, is born in a hospital and is subsequently a resident of that hospital throughout the remainder of that month, the baby is considered to be a resident of the hospital throughout the month of his/her birth and no parental resources are deemed OR
- An infant who is born disabled, and who remains in the hospital for an extended time after birth is a resident of the medical institution from the date of birth and no parental resource are deemed.
- An emancipated child

Married Couple where Both Individuals Institutionalized

If both spouses are institutionalized, apply the following rules:

- Calculate the individual's countable gross unearned income
- Calculate the spouse's countable gross unearned income
- Combine the countable gross unearned income of the couple

- Apply unearned income deductions to the couple's income to determine the countable net unearned income
- Calculate the individual's countable gross earned income from all sources (including self employment income)
- Calculate the spouse's countable gross earned income from all sources (including self employment income)
- Combine the countable gross earned income of the couple
- Apply earned income deductions to the couple's income to determine the countable net earned income
- Add the countable gross unearned income and the countable gross earned income to determine the total gross countable income for the eligible couple
- Compare net countable income to the state defined Medically Needy Income Eligibility Standard.

    Exception: If spouses are both institutionalized but ineligible when treated as a couple, treat each spouse as an single institutionalized individual

Single Institutionalized Individual

- Total the individual's countable gross unearned income
- Apply unearned income deductions to determine the net unearned income
- Total the individual's countable gross earned income from all sources (including self employment income)
- Apply earned income deductions to determine the net earned income
- Total the individual's countable net earned and unearned income to give total net income.
- Compare net countable income to the state defined LTC Income Eligibility Standard.

Married Couple where One is Institutionalized and Other is Community Spouse

- Calculate the individual's countable gross unearned income
- Apply unearned income deductions to determine the net unearned income
- Calculate the individual's countable gross earned income from all sources (including self employment income)
- Apply earned income deductions to determine the net earned income
- Add the countable net unearned income and the countable net earned income to determine the total net countable income
- Compare net countable income to the state defined LTC Income Eligibility Standard.

Final Steps

1. Apply earned income deductions to determine the net earned income
2. Add the countable net unearned income and the countable net earned income to determine the total net countable income
3. Compare net countable income to the state defined state defined LTC Income Eligibility Standard.
4. Subtract the monthly LTC IES income limit for 1 person from the net countable income. This is the LTC Spend Down Liability. For more information on Spend Down, see the `Cúram Income Support for Medical Assistance Spend Down Guide`.

Deductions

After being determined eligible for LTC Medicaid, some individuals who are residing in nursing homes, or who are receiving home and community-based (HCB) waiver services may be required to contribute a portion of their income toward the cost-of-care they receive. The post eligibility process involves determining the exact amount an individual is obligated to pay to the medical institution, nursing home, or HCB waiver services provider. The provider is responsible for collecting from the individual that

individual's share of the cost-of-care. Medicaid reduces its payment to the provider by the amount of the individual's cost-of-care liability.

These are the steps to follow when determining the individual's contribution towards cost of care. The individual's contribution towards cost of care is calculated on a monthly basis.

- Determine the individual's gross earned income AND
- If the individual's earned income is greater than zero, apply the Earned Income Deduction to earned income AND
- Total the individual's unearned income and earned income to give gross income for the individual.
- If the individual's gross income is greater than zero, apply the Personal Needs Allowance AND
- If the individual's remaining gross income is greater than zero, apply the Community Spouse Needs Allowance AND
- If the individual's remaining gross income is greater than zero, apply the Family Dependent Allowance AND
- If the individual's remaining gross income is greater than zero, apply the Medical Expense Deduction AND
- If the individual's remaining gross income is greater than zero, apply the Home Maintenance Allowance AND
- If the individual's remaining gross income is greater than zero, apply the Legal Guardian Expense Deduction.
- The remaining amount after the deductions/allowances are applied, is the individual's contribution towards cost of care for the month.

Earned Income Deduction

See the Earned Income Deductions sub-section of the Adult - Common Income Rules chapter of the `Cúram Income Support for Medical Assistance Program Guide`.

Personal Needs Allowance

Nursing Facility

For individuals who reside in a nursing facility apply the following unless an exception applies:

- Deduct the Basic Personal Needs Allowance amount from the individual's remaining gross income

Nursing Facility Exception

- The individual is a veteran or a surviving spouse of a veteran AND
- The individual is in receipt of a reduced Veterans Administration Pension AND
- Deduct the Reduced VA Pension Personal Needs Allowance amount ($90) from the individual's remaining gross income.

Elderly Waiver

- The individual is on an Elderly /Disabled (E/D) waiver
- Deduct a personal needs allowance of 100% of the federal poverty rate from the individual's remaining gross income.

Mental Retardation or Developmental Disabled Waiver

- The individual is on a Mental Retardation or Developmental Disabled waiver
- Deduct a personal needs allowance of 100% of the federal poverty rate from the individual's remaining gross income.

Brain Injury Waiver

- The individual is on a Brain Injury waiver
- Deduct a personal needs allowance of 100% of the federal poverty rate from the individual's remaining gross income.

Physical Disabilities Waiver

- The individual is on a Physical Disabilities waiver
- Deduct personal needs allowance of 300% of the SSI rate from the individual's remaining gross income.

Community Spouse Needs Allowance

- The individual has a community spouse AND
- A court or fair hearing does not determine the amount an institutionalized individual must allocate to their community spouse OR
- A court or fair hearing determines the amount an institutionalized individual must allocate to their community spouse

Non Court Order/ Fair Hearing Determination of Community Spouse Needs

- The individual agrees to give the community spouse the allowance AND
- Determine the Community Spouse Needs Allowance as follows:

  1. Determine the community spouse's shelter costs for the month. Community spouse shelter costs can include the following:
     - Rent
     - Mortgage principal and interest
     - Taxes and insurance for principal place of residence. This includes renters insurance
     - Maintenance fees
     - The standard utility allowance established under the Food Stamp program
  2. Subtract the shelter limit from the community spouses shelter costs (as determined above)
  3. Determine the Community Spouse's Income Allocation
  4. If there are Excess Shelter Costs (from 2 above):
     - Add the Excess Shelter Costs to the Minimum Income Allocation. (This amount is called the Community Spouse's Income Allocation)
  5. If there are no Excess Shelter Costs (from 2 above)
     - The Community Spouse Income Allocation is assigned the value of the Maximum Income Allocation amount.
  6. Determine the community spouse's gross income (monthly).
  7. Subtract the community spouse's gross income from the Community Spouse Income Allocation giving the Community Spouse Needs Allowance
  8. If the community spouse's gross income is equal to or greater than the Community Spouse Needs Allowance, no Community Spouse Needs Allowance is deducted from the institutionalized spouse's income OR
  9. If the community spouse's gross income is less than the Community Spouse Needs Allowance (the Community Spouse Needs Allowance amount is deducted from the institutionalized spouse's remaining gross income.

Court Order/ Fair Hearing Determination of Community Spouse Needs

- A court order /fair hearing requires the individual to pay support to the spouse at home AND

- The court order amount is greater than the Community Spouse Needs Allowance.
- The Community Spouse Needs Allowance is assigned the value determined by the court order. Deduct the Community Spouse Needs Allowance from the individual's remaining gross income.

Family Dependent Allowance

- The individual has dependent family members other than the community spouse AND
- The dependent family member meets the criteria for a family dependent AND
- The individual agrees to give the dependent family member(s) the allowance AND
- The dependent family member(s) live with the community spouse OR
- The dependent family member(s) do not live with the community spouse.

Dependent Family Member(s) Live with the Community Spouse

- If the individual's dependent family member(s) live with the individual's spouse, determine the Family Dependent's Allowance as follows:
  - For each family dependent, determine the family dependent's monthly countable gross income AND
  - If the family dependent's gross income is greater than the Minimum Spousal Standard, no family dependent allowance is deducted for that family dependent OR
  - If the family dependent's gross income is less than the Minimum Spousal Standard, subtract the family dependent's gross income from the Minimum Spousal Standard AND
  - Divide the result by three.

    Add the results together from step 4 (above) for each family dependent, to give the total Family Dependent Allowance.

Dependent Family Member(s) do not Live with the Community Spouse

- If the individual's dependent family member(s) do not live with the individual's spouse, determine the Family Dependent's Allowance as follows:
  - Add together the gross countable income (monthly) for all family dependents AND
  - Subtract the total dependent's income from the Medically Needy Income Eligibility Standard (MNIES) for the number of dependents

    This gives the total Family Dependents Allowance that is to be deducted from the individual's remaining gross income

Medical Expense Deduction

In order for a Medical Expense to be considered deductible it must meet all of the following criteria:

- The medical expense is allowable AND
- The medical expense was incurred by the individual AND
- The medical expense was not used already to meet spend down AND
- The medical expense is not subject to third party payment AND
- The medical expense was not already paid by Medicaid

  Deduct the medical expense paid by the individual. If the individual pays the premium less often than monthly (such as quarterly) prorate the amount paid by the number of months covered by the payment to obtain the monthly amount to deduct for this medical expense OR

  If the medical expense is a combined family premium, deduct the portion of the combined family premium that is paid for the individual.

Home Maintenance Allowance

- The individual is not living in their home AND

- A doctor certifies that the individual is expected to return home within 6 months AND
- The individual has no community spouse OR
- The individual has a community spouse and the community spouse is not living in the home AND
- Determine the shelter expenses for the individual's home.
- The shelter expenses are greater than the SSI Level for an individual, the Home Maintenance Allowance is assigned the value of the SSI Level for an individual.
- The shelter expenses are equal or less than the SSI Level for an individual, the Home Maintenance Allowance is assigned the value of the Shelter Expenses.

Legal Guardian Expense Deduction

- The individual has a guardian AND
- The guardianship fee is equal to or less than the guardianship fee limit
  - Deduct the guardianship fee.
- If the guardianship fee is greater than the guardianship fee limit The guardianship fee is assigned the value of the guardianship fee limit.
  - Deduct the guardianship fee.

Additional Long Term Care Processing

Change in Circumstance Processing

Change of circumstances processing occurs when there has been an evidence change on the Integrated Case. When a change of circumstances has occurred which impacts a Long Term Care product delivery, the system reassesses that case. Reassessment detects whether an individual is still eligible for Long Term Care and whether there is a change in their cost of care liability. Reassessment also detects when resources are transferred that are required for spousal impoverishment, and resources that is transferred inappropriately after eligibility has been established.

This section provides an overview of change in circumstance processing when evidence changes are made at the Integrated Case level and when changes result in the individual being no longer eligible. This section also summarizes the impact of specific evidence changes on Long Term Care eligibility.

Impact of Evidence Changes on Long Term Care Eligibility

This section describes the impact that specific evidence changes can have on Long Term Care eligibility.

Household Changes

Household member changes have the potential to enable household members to be eligible for different program options. In general, the removal or addition of other household members will not impact the eligibility of the institutionalized individual although, if the household member who is removed is a spouse or a dependent of the institutionalized individual, the case will be reassessed for cost of care amounts.

Income Changes

Once eligibility has been determined for an institutionalized individual they are treated as a single income unit thereafter, and must always have income under a specified Long Term Care income limit. New/changed income evidence will trigger reassessment to run the Income Eligibility rules for Long Term Care for a single institutionalized individual. If the rules determine that the individual is over the income limit then they are ineligible for Long Term Care from the beginning of the following month. If the rules determine that the individual is still within the income limit the system will trigger reassessment to run post eligibility rules to redetermine the individual's contribution towards cost of care. An increase in income is likely to cause the individual to contribute more to their cost of care. Likewise, a decrease in

income will reduce the individual's contribution to their cost of care. The reassessment will display the new amount in the reassessment result.

Income changes for a spouse or household member who is a family dependent will trigger reassessment to run the post eligibility rules for cost of care. The new contribution to cost of care will be displayed in the result. Income changes for any other household member will have no effect on the institutionalized individual's Long Term Care coverage but may impact their cost of care liability.

Expense Changes

Changes in expense evidence for the institutionalized individual can potentially affect allowable income deductions and the post eligibility cost of care amount - the system will trigger reassessment to run the Income rules for a single institutionalized individual. Providing the individual is still eligible the system will run the post eligibility rules to determine the new contribution towards cost of care.

Expense changes for a spouse will trigger reassessment to run the post eligibility rules to redetermine the cost of care. Expense changes for any other household member will have no effect on the institutionalized individual's Long Term Care coverage but may impact their cost of care liability.

Resource Changes

Once eligibility has been determined for an institutionalized individual (without spousal impoverishment), the individual must always have resources under a specified Long Term Care resource limit. Any new resource evidence recorded for the individual, including resource transfer evidence will trigger reassessment to run the Resource Eligibility rules for Long Term Care.

If the rules determine that the individual is over the resource limit then they are ineligible for Long Term Care from the beginning of the following month based on program alignment rules.

When eligibility has been determined for an institutionalized individual with spousal impoverishment, any resource changes must be monitored against allowable amounts in the spousal impoverishment once they are within the protected period.

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