IBM Cúram Social Program Management

Cúram Long Term Care Medical Assistance Guide

Version 6.0.4

Note

Before using this information and the product it supports, read the information in Notices at the back of this guide.

This edition applies to version 6.0.4 of IBM Cúram Social Program Management and all subsequent releases and modifications unless otherwise indicated in new editions.

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Chapter 1

Introduction

1.1 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 program within Cúram Medical Assistance™.

1.2 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.

1.3 Available Documentation

Supporting documentation relating to Medical Assistance and associated programs, including Long Term Care Medical Assistance can be found in the Business Analysts guide titled "Cúram Global Medical Assistance Program Guide". Caseworkers may also find the business guides for other Medical Assistance programs useful. For Spend Down, see the "Cúram Medical Assistance with SpendDown Guide". For Children's Health Insurance Program, see "Cúram Children's Health Insurance Program Guide".

Chapter 2

Long Term Care Medical Assistance Overview

2.1 About Long Term Care Medical Assistance

Long Term Care Medical Assistance is a Medical Assistance program that provides 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.

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.

The remainder of this section describes additional conditions which must be met by individuals applying for Long Term Care Medical Assistance.

2.1.1 Certification Requirements

Institutionalized individuals who are eligible for, or in receipt of standard Medical Assistance Services under one of the existing programs are automatically eligible 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 program, but who are aged, blind or disabled according to SSA disability criteria may also be eligible for Long Term Care coverage if they are within a special income limit set by the state. Institutionalized individual's must also be certi-

fied as needing a specified level of medical or nursing home care. This certification 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.

2.1.2 Income Limits

All applicants for Long Term Care Medical Assistance must pass an income assessment. This income assessment determines whether or not an individual's income is under the required income limits. In the initial month of eligibility, the institutionalized individuals are categorized into an appropriate income unit according to whether or not they are a single individual, an unemancipated child, married with an institutionalized spouse or married with a community spouse. Once the individual is eligible for the first month, they are usually treated as a single institutionalized individual for every month thereafter.

2.1.3 Resource Limits

In addition to passing an income assessment, all applicants for Long Term Care Medical Assistance must pass a resource assessment. This resource assessment determines whether or not an individual's resources are under the required resource limits. In the initial month of eligibility, institutionalized individuals are categorized into the same units for resources as those used for income. Once the individual is eligible for the first month they are usually treated as a single institutionalized individual for every month thereafter. Special provisions called Spousal Impoverishment provisions apply to individuals who became institutionalized after 1989 and who have a community spouse.

Spousal Impoverishment is a term used to refer to additional benefits provided to a couple when only one spouse resides in a medical institution and the other spouse is in the community, or when only one spouse is eligible for Home and Community Based Waiver services and the other is not. The purpose of this provision is to allow the community spouse to keep additional resources. 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'.

2.1.4 Declaration of Resources

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 'lookback 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 and is 36 months or 60 months depending on the type of resource and when the resource was transferred.

2.1.5 Individual Contributions

Unlike other Medical Assistance programs, 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 earned income.

2.2 The Cúram Long Term Care Program

The Cúram Long Term Care Medical Assistance™ program operates similarly to the other Cúram programs in that the caseworker enters evidence for an individual and his or her family which is evaluated against a set of rules to determine whether or not an individual is eligible for coverage. Long Term Care eligibility determination is run as part of the existing cascading eligibility workflow and has an equal priority in the hierarchy of Medical Assistance Program eligibility as other Categorically Needy Programs and Medically Needy Programs, but it takes place before Cost Sharing Programs and Medically Needy Programs with SpendDown. Long Term Care is also available as a SpendDown program.

The Long Term Care program is unique in that system processing functionality is triggered when evidence is activated and before eligibility is checked. This functionality checks whether or not the evidence suggests that the institutionalized individual should be sanctioned for transferring assets specifically in order to qualify for Long Term Care coverage.

Also unique to the Long Term Care program is the automatic generation of spousal impoverishment records at product delivery level under spousal impoverishment provisions. The function of this record is to enable the system to monitor the transfer of assets from an institutionalized spouse to their community spouse. The Long Term Care program also includes functionality to calculate the amount an individual must pay towards their own cost of care as part of patient pay liability regulations.

2.2.1 Long Term Care Evidence

The Cúram Long Term Care Medical Assistance program uses much of the existing Cúram Medical Assistance evidence. Each of the following evidence categories, however, has been extended to enable the system to automatically determine an individual's eligibility for the Long Term Care Program. The evidence chapter provides a summary of the evidence entities that are necessary to capture the additional information required to enable the system to automatically determine the client's eligibility for the Long

Term Care Medical Assistance programs. Existing standard medical assistance evidence, although used in this program, is not specified in this chapter.

Extensions to Household Evidence

The household evidence has been extended to include entities to record medical institution and level of care information for an institutionalized individual as well as the facility to record a temporary absence from an institution. New evidence has also been added to aid in patient pay liability amount calculations.

Extensions to Income Evidence

The income evidence has been extended to include entities to record annuity income as well as entities and functionality to enable an income trust schedule to be set up and existing income assigned to it.

Extensions to Resource Evidence

Although the Long Term Care program uses much of existing Medical Assistance resource evidence, there have been some significant changes in how evidence is recorded in this area. The existing evidence has been changed to require a caseworker to record ownership evidence for each resource. The resource itself is now recorded without being attributed to any household member and every individual's percentage ownership of that resource is recorded separately (even if there is only one owner).

New functionality has also been added to enable caseworkers to transfer ownership from one individual to another and to keep records of such transactions. This functionality is necessary for resource transfer sanction determination and spousal impoverishment processing. The resource evidence has also been extended to include entities to record annuity and annuity beneficiary evidence and the addition of repayment terms to certain types of liquid resource evidence.

Extensions to Expense Evidence

The expense evidence has been extended to include a new evidence entity to record legal guardian expense information for use in patient pay liability determination.

2.2.2 Long Term Care Evidence Activation Processing

Evidence activation for Long Term Care Medical Assistance has been extended to determine whether or not Resource Transfer Sanctions apply to the individual. When evidence is activated on an Integrated Case that includes medical institution evidence, the following processing occurs automatically:

- Creation of Automatic Resource Transfer Record(s)
- Creation of Resource Transfer Sanction Record(s)
- Creation of Sanction Member Record(s)

This chapter describes what is involved in each of these processing steps and why they are run.

2.2.3 Eligibility Determination and Product Delivery Case Creation

Eligibility Determination for the Long Term Care Medical Assistance program includes system processing to determine spousal impoverishment values. It also provides results from which a user can choose to add a program, which means creating a product delivery case. This also includes the steps necessary to create a Long Term Care product delivery case and view spousal impoverishment details.

2.2.4 Additional Long Term Care Processing

There are a number of ways in which the system handles the reassessment of a case when a change of circumstance is recorded. For example, the system handles reassessment for a Long Term Care product delivery case in a specific way when evidence changes in circumstances are activated at the integrated case level. The Additional Long Term Care Processing chapter describes this change of circumstance processing as well as describing how eligibility can be renewed on a product delivery at the end of the certification period. This chapter also describes new functionality that has been included for Long Term Care Medical Assistance to enable caseworkers to transfer ownership of a resource from one individual to another or from an individual to a trust.

Chapter 3

Long Term Care Evidence

3.1 Introduction

During eligibility determination, the system evaluates an individual's or household's evidence against rules to determine the individual or household's potential eligibility for medical assistance care. This overview outlines the evidence used specifically for Long Term Care Medical Assistance eligibility determination and includes information on new entities created for this program as well as changes to existing entities. Long Term Care evidence can be entered at any time during the eligibility process.

Although Long Term Care medical assistance coverage applies to a single individual, it is necessary to capture details of that person's family member's personal circumstances, income, resources and expenses. This is because in initial eligibility determination, the institutionalized individual may be assessed in a unit with one or more family members. Also deductions may apply for family member's expenses in the determination of the patient pay liability towards cost of care.

Once the individual is deemed eligible, they are treated as a single institutionalized individual thereafter.

3.2 Extensions to Household Evidence

An individual must be either living in an institution or participating in a home and community based waiver services program to qualify for Long Term Care medical assistance.

Medical Institution evidence records details of a household member's stay in a medical institution or participation in a Home and Community Based Waiver program. These details include information on the institution type and the date entered as well as information on who placed the individual in the institution. A Medical Institution may be defined as a state licensed Medical Assistance qualified nursing home or a Home and Community

Based Waiver. Inpatient psychiatric hospitals, out of state rehabilitation centers, and boarding and shelter homes do not fall under the definition of Medical Institution. Home and Community Based waivers provide Medical Assistance funds to help people who would be eligible for nursing home care to remain in their own homes or other community-based settings. The Home and Community Based Waivers covered by the Cúram Medical Assistance Long Term Care program are Brain Injury Waiver, Physical Disabilities Waiver, Mentally Retarded/Developmentally Disabled (MR/DD) Waiver and Elderly Waiver.

Medical Institution Temporary Absence evidence records details of an individual's temporary absence from a Medical Institution or from a Waiver Program. Reasons for such an absence include hospitalization or a family visit. In general, an individual will be allowed to leave the institution for a period of 14 days without losing Long Term Care Coverage.

To be eligible for Long Term Care coverage, an individual must require one of a specified list of levels of care and be certified as such by a qualified physician. Level of Care evidence captures details of the level of care required by the individual.

The Long Term Care program uses the existing Medical Assistance disability evidence to determine whether or not an individual may qualify under a disability category. The disability entity has been extended to include extra disability types that apply specifically to Long Term Care medical assistance,

If a household member is eligible for the Long Term Care program, a post eligibility process is carried out which calculates how much the household member should contribute towards their 'cost of care'. The 'cost of care' amount or patient pay liability for a household member, is determined based on their total monthly income with some deductions made for their personal needs, medical expenses, spouse and family dependents. Cost Of Care Allowance evidence captures details to support this process, for example, whether or not an institutionalized individual agrees to give their community spouse a deductible amount or whether or not a court has determined the amount to be paid to the spouse.

Spousal Cooperation evidence records details of the willingness of a household member to cooperate with an institutionalized spouse when establishing eligibility for Long Term Care Medical Assistance under Spousal Impoverishment provisions. Spousal Impoverishment processing carries out an assessment on the resources of both spouses. It is presumed that all spousal resources are actually available. In cases where spousal resources can be proved to be unavailable, i.e. one member of a couple, a community spouse, refuses to cooperate with Medicaid, or in cases where a spouse cannot be found, the client may obtain Long Term Care Medical Assistance coverage by assigning spousal support rights to the State and allowing the State to pursue the Community Spouse for withheld resources.

3.3 Extensions to Resource Evidence

Resource evidence is used extensively in eligibility determination for the Long Term Care Medical Assistance program. It is used in system processing on evidence activation (and before eligibility determination) to determine whether or not an individual, their spouse or any individual acting on their behalf has transferred an asset in order to qualify for Long Term Care medical assistance. If it is determined that this is so, then a sanction may be applied against the individual preventing them from receiving Long Term Care Medical Assistance coverage for a period of time. The Resource Transfer and Ownership evidence entities have been extended to include information needed for this sanction determination.

Resource evidence is also used in Long Term Care eligibility determination in the traditional way to determine whether or not an individual is resource eligible under a specified resource limit. For institutionalized individuals with community spouses, spousal impoverishment calculations may also be performed on this evidence to determine whether or not they qualify for Long Term Care coverage with the provision that they transfer ownership of a certain amount of their assets within a specified period of time.

The resource and ownership entities have been changed to attribute ownership evidence to every resource. The participant and ownership type details have been removed from the Business Asset, Trust, Property, Burial Plot, Vehicle and Liquid resource entities. This information is now recorded on the ownership entity. At least one ownership evidence record must be added for a resource. Ownership evidence captures the percentage of a business, property, burial plot, vehicle, annuity, life insurance policy, or liquid resource owned by an individual. The percentage owned is used to determine the individual's share of the resource or the business. An ownership record is added for each participant, specifying their percentage share of the resource. Ownership evidence has also been extended to record details of the transfer of ownership of a resource to another individual or trust and the reversal of a transfer of ownership to an individual. Note that it is not possible to reverse a resource transfer from an individual to a trust.

The resource evidence has also been extended to include annuity and annuity beneficiary entities. Annuity evidence captures details such as the name of the institution with whom the annuity is held, the type of institution, the value of the annuity, and the annuity type. Annuity beneficiary evidence relates directly to the annuity and captures details of the annuity beneficiaries associated with the annuity. It includes information such as the name of the annuity beneficiary, the relationship of the purchaser to the annuity beneficiary and the type of annuity beneficiary. At least one ownership, annuity beneficiary and annuity income evidence records, must be added for annuity evidence.

3.4 Extensions to Income Evidence

The existing income evidence is used in Long Term Care eligibility determination with some additions. It is important to note that there is a special income limit (SIL) for Long Term Care against which every institutionalized

individual must be assessed, regardless of whether or not they qualify under income rules for any other medical assistance program.

Income Trust Schedule evidence captures details of the incomes and the portions of which that a participant has agreed to place in an Income Trust in order to be income eligible for the Long Term Care Medical Assistance program. States which do not allow individuals to use SpendDown to become income eligible for coverage generally allow individuals to place their excess income into a non countable Income trust in order to become income eligible for medical assistance coverage for Long Term Care services. The income trust has the provision that the State is created as the primary beneficiary and upon the death of the individual, the State is reimbursed for all medical assistance costs related to the individual. The income assigned to the income trust is not counted for income eligibility, but is counted when determining the individuals liability to their cost of care for the Long Term Care program.

Assign Income evidence records details of income of certain types which is assigned to the trust schedule.

Annuity Income evidence captures details of regular payments made from an annuity to an annuitant. An annuitant is an individual or an organization who will benefit either solely or partially from the annuity. Annuity income can only be recorded when there is a annuity record. Annuity income includes interest and dividends earned from a annuity or regular cash withdrawals from an annuity.

3.5 Extensions to Expense Evidence

The existing expense evidence is used in Long Term Care eligibility determination with the addition of the Legal Guardian Expense entity. Legal Guardian Expense evidence captures details of a Legal Guardian Expense incurred by a household member. A Legal Guardian is an individual who is appointed to represent the household member. If the Legal Guardian charges a monthly fee, this fee can be deducted as an expense from the household member's gross monthly income during the post eligibility income calculations to determine the patient pay liability.

Chapter 4

Long Term Care Evidence Activation Processing

4.1 Introduction

As mentioned earlier in this guide, evidence activation processing has been extended to determine whether or not Resource Transfer Sanctions apply to the individual. The extended processing only occurs when evidence is activated on an Integrated Case that includes medical institution evidence. This is because this processing is only relevant for Long Term Care Medical Institution cases and all individuals applying for this program will have medical institution evidence.

This chapter describes the automatic processing which occurs on evidence activation to create the necessary records to track Resource Transfer Sanctions. This chapter also describes how a user can access these records in the system once they have been created.

4.2 Automatic Processing on Evidence Activation

This section describes in detail the processing that occurs on evidence activation which results in the automatic creation of automatic resource transfer records, resource transfer sanction records, and sanction member records.

4.2.1 Automatic Creation of Automatic Resource Transfer Records

When evidence is activated on an Integrated Case that includes medical institution evidence, the system is triggered to evaluate this type of evidence in order to determine if there is an invalid resource transfer, and if so to create an Automatic Resource Transfer record. The circumstances used to determine whether or not there is an invalid resource transfer are described as follows.

On application for Long Term Care Medical Assistance Programs, an institutionalized individual's total countable resources must be less than or equal to the state defined resource limit. In order to achieve this, an institutionalized individual may transfer some resources to reduce his/her resources. System processing can determine which resource transfers are valid and which are done specifically to qualify for Long Term Care coverage. Resources transfers can be recorded manually by the caseworker using the Resource Transfer or Ownership entities. However, resource transfers also occur when specific types of evidence are added which are not deemed to be actuarially sound or seem to be benefiting someone other than the institutionalized individual. For example, when an individual creates a trust fund for which they are not the beneficiary or creates an annuity which will pay out for longer than their life expectancy. When evidence is activated on an integrated Case that includes institutional evidence the system is triggered to evaluate this type of evidence in order to determine if there is an invalid resource transfer, and if so to create an Automatic Resource Transfer record.

The system automatically creates an Automatic Resource Transfer record for liquid resource, property, annuity or trust evidence of certain types that is added or updated for the institutionalized household member or their community spouse, if the uncompensated value for the record is calculated to be greater than zero. The uncompensated value is the amount that the individual transferred to another without receiving adequate compensation. The system determines the uncompensated value from rules and calculations according to the specific type of evidence. For example, if someone has a life estate with powers ownership of their property, there will always be an associated uncompensated value which is calculated using the appropriate life estate factor for their age.

4.2.2 Automatic Creation of Resource Transfer Sanction Records

When evidence is activated on a case that includes medical institution evidence, the system is also triggered to evaluate evidence on the Ownership, Resource Transfer and Automatic Resource Transfer evidence entities to determine if there have been any invalid resource transfers. For any resources that have been transferred for less than fair market value (have an uncompensated value), the system runs the appropriate rules to determine if the resource transfer merits a penalty sanction. For example, institutionalized individuals are allowed to transfer resources to a spouse or blind or disabled child without being penalized. If the resource should be subject to a penalty, the system will automatically create a Resource Transfer Sanction record for the 'invalid' transfer of the resource, the duration of which is automatically determined by dividing the uncompensated value of the resource transfer by the average monthly nursing home private pay rate in effect at the time of the transfer.

As a result of recent legislative changes, the method of calculating the sanction period and the sanction start date vary depending on whether the re-

source transfer occurred before or after February 8th, 2006.

4.2.3 Automatic Creation of Sanction Member Records

Once Resource Transfer Sanction records have been created for each invalid resource transfer, the system automatically collates all records with dates that overlap into a single Sanction Member record for the household member. This is because overlapping resource transfer sanctions are applied consecutively. Resource Transfer Sanction record dates can overlap if a caseworker transferred a resource that generated a resource sanction that fell within another Resource Transfer Sanction record's dates.

The start date of the Sanction Member record is usually set to the earliest disqualification start date of the individual Resource Transfer Sanction records for the household member. The system derives the end date of the Sanction Member record from the combined durations of all overlapping Resource Transfer Sanction records for the individual. In the case where both members of a couple are institutionalized, any sanctions are divided equally between them.

This process is repeated for any subsequent Resource Transfer Sanction records.

4.2.4 Viewing Records Created in Automatic Processing

Once the system has created records for the automatic resource transfers, resource transfer sanctions and sanction member records these records can be viewed from the Integrated Case Member record.

Sanctions generated from invalid resource transfers can be identified by the sanction type of 'Invalid Resource Transfer'. From these records the caseworker can drill down to individual resource transfer sanction record details and the resources associated with these records. Details of any automatic resource transfers can also be viewed at Integrated Case level.

Chapter 5

Eligibility Determination and Product Delivery Case Creation

5.1 Introduction

The Cúram Medical Assistance module currently provides the capability to determine Medical Assistance eligibility for the Categorically Needy Medical Assistance Programs, Medically Needy Programs and Medically Needy programs with SpendDown. The Medical Assistance Program has been extended to include the Long Term Care Programs for institutionalized individuals who are in receipt of or eligible for other Medical Assistance programs, or who are aged, blind or disabled and qualify within a special income limit. The Long Term Care programs are also available with a SpendDown option.

This chapter provides a high level summary of the check eligibility process for medical assistance programs including Long Term Care. The check eligibility process creates eligibility results. This chapter also describes the process for viewing eligibility results for medical assistance programs including Long Term Care. A user can decide to create a Long Term Care product delivery case for individuals who are deemed eligible. The final section of this guide is on the create product delivery case process.

5.2 Check Eligibility for Medical Assistance Programs including Long Term Care

The Check Medical Assistance Eligibility process has been extended to include eligibility determination for the Long Term Care program. The workflow and rules for Long Term Care eligibility are executed for any individual who has a Medical Institution record. Long Term Care Medical Assistance has an equal priority in the hierarchy of Medical Assistance Program eligibility as other Categorically Needy Programs and Medically Needy Pro-

grams, but it takes place before Cost Sharing Programs and Medically Needy Programs with SpendDown.

Starting the eligibility check will trigger the categorical eligibility workflow which will determine whether or not an individual with medical institution evidence is categorically eligible for Long Term Care coverage. The system will then identify the appropriate income and resource unit for any eligible individual(s). The possible income and resource groups in the month of eligibility are a institutionalized disabled or blind child, a single institutionalized individual, a married couple where both are institutionalized or a married institutionalized individual with a community spouse. In the month following the month of eligibility and every month thereafter, an institutionalized individual is treated as a single individual income and resource unit.

In all cases, the rules will determine whether the individual passes the non financial requirements, level of care and 30 consecutive day requirements. The system will then run through the income and resource rules for the appropriate income and resource unit.

In the case of a blind or disabled institutionalized child, the income and resources of the parents are deemed to the child in the month of eligibility. The child must then qualify under specific Long Term Care income and resource limits. A single institutionalized individual must also qualify under the same income and resource limits. Each member of a couple, where both spouses are institutionalized are 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 twice the resource limit for a single individual.

If the income/resource 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 special date called the Assessment Date. The rules processing determines an appropriate Spousal Share for each spouse. If the institutionalized individual's Spousal Share is above the state defined asset limit for Long Term Care Medical Assistance Programs (usually $2000), and the Community Spouse's Spousal Share is below the Maximum Spousal Share, the institutionalized individual must reduce their share of the assets, usually by transferring them to the community spouse.

Rules processing within the system calculates 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 assets within a specified period defined by the state, known as the protected period. Once the caseworker selects the Product Delivery, this information is stored in the Spousal Impoverishment entity.

Once an individual passes the eligibility rules for Long Term Care Medical Assistance, the system triggers assessment to run post-eligibility rules to determine the individual's contribution towards 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.

If an institutionalized individual fails Long Term Care eligibility because of excess income, they can use the Check Medical Assistance with SpendDown button to check eligibility for Long Term Care with SpendDown programs. For more information on SpendDown, see the guide the "Cúram SpendDown Medical Assistance Guide ".

5.3 View Eligibility Decisions for Medical Assistance Programs including Long Term Care

Upon completion of the check Medical Assistance workflow, a task is created in the caseworker's inbox. This task links to a list of Medical Assistance Eligibility Results. These results are the Medical Assistance programs for which the household members are eligible, including Long Term Care programs, where appropriate. The list of the Long Term Care Medical Assistance Programs under which an institutionalized individual may potentially be eligible is as follows:

- Long Term Care - Institutional
- Long Term Care - Elderly Waiver
- Long Term Care - Physical Disability Waiver
- Long Term Care - Brain Injury Waiver
- Long Term Care - MR/DD Waiver

Additional information has been added to household members displayed in eligibility results which describes some conditions of eligibility specific to Long Term Care Programs. These are the Patient Pay Liability and Asset Transfer Required information details.

Patient Pay Liability 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 Household Member details on the Medical Assistance Eligibility Results.

Asset Transfer Required refers to the amount of assets that an institutionalized individual must agree to transfer to their spouse within a defined protected period according to spousal impoverishment rules. The amount of resources required to be transferred within this period is appended to the Household Member details on the Medical Assistance Eligibility Results.

Note that the caseworker can also view a list of ineligible decisions from the Medical Eligibility Results.

5.4 Create Long Term Care Medical Assistance Product Delivery Case

Caseworkers can create Long Term Care product delivery cases for household members who are eligible for Long Term Care programs as displayed in Medical Assistance eligibility results. The selection of a Long Term Care Medical Assistance program may have implications for other members of the household on other Medical Assistance programs. 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 program where a transfer of assets is required assumes that the institutionalized individual has agreed to transfer assets to their spouse. In certain cases, 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 caseworker applies for a Long Term Care program, a program delivery and, where appropriate, spousal impoverishment record are created for the client. The caseworker enters a receipt date for the selected Long Term Care medical assistance program, and creates the program. When the caseworker confirms that they wish to create the selected Medical Assistance program the product delivery case can be viewed. In the case of Long Term Care programs, this assumes that the household member concerned is willing to accept any existing conditions of eligibility, i.e. patient pay liability.

Long Term Medical Assistance functionality uses existing product delivery functionality within the product with the addition of an extra link to view the spousal Impoverishment record. The system automatically creates the Spousal Impoverishment Details record for a Long Term Care Medical Assistance product delivery when the Product Delivery is created for a case that has spousal impoverishment conditions. Spousal Impoverishment details include information on the Minimum and Maximum Spousal Share, start and end date of the protected period and the amount of asset transfer currently required.

Please note that for Long Term Medical Assistance program cases, the fin-

ancial group displayed on the Product Delivery Home page may differ for initial eligibility and ongoing eligibility. This is because the income and resource unit for Long Term Care Medical Assistance Programs changes once the institutionalized individual has become eligible.

Chapter 6

Additional Long Term Care Processing

6.1 Introduction

This chapter covers the following additional Long Term care Processing

- Change in Circumstance Processing
- Eligibility Renewal
- Manual Ownership Transfer Process

6.2 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 case, the system reassesses that case. Reassessment differs from eligibility renewal in that only a subset of rules are run in reassessment. 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 are transferred illegally 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.

6.2.1 Evidence Changes at the Integrated Case Level

On Integrated Cases that include medical institution evidence, certain evidence changes trigger case processing and rules processing regardless of

whether or not there is an active product delivery. For example, when an individual is determined ineligible for Long Term Care coverage due to sanctions imposed from transferring assets to another individual, then transferring the assets back may render them eligible for Long Term Care coverage. In this case, transferring the asset back will trigger case processing to redetermine the sanction period, if any.

Other evidence changes that trigger case processing are resource evidence changes that trigger the generation of Automatic Resource Transfer evidence records, evidence changes that involve the Resource Transfer or Ownership entities and changes in institutionalization of sanctioned household members.

The history of application for any individual applying for Long Term Care coverage must be started from when they first apply for Long Term Care and are institutionalized, regardless of whether or not they are eligible for coverage.

6.2.2 Changes in Circumstances Causing Ineligibility

Certain evidence changes cause the individual to lose coverage in the month after the change occurs. In this case, the system automatically closes the Product Delivery and sets the end date to the last day of the month in which the change occurred. Some examples of this type of evidence are when the individual's income is no longer within the program income limits or when the individual or community spouse performs an invalid resource transfer

6.2.3 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 patient pay liability 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.

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

Resource Changes

Once eligibility has been determined for an institutionalized individual (without spousal impoverishment) they are treated as a single resource unit thereafter and 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 for a single institutionalized individual. 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. Any new or updated resource transfer, liquid resource, ownership, property, trust or annuity evidence for the individual or community spouse for an active integrated case also triggers reassessment to run the case and rules processing for sanctions.

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 record (which is managed by case processing) once they are within the protected period. In this case they are not subject to the normal resource test until the spousal impoverishment record is closed (once they are still eligible). Each resource transfer to

the spouse has the potential to complete the protected period, or to reduce the amount that must be transferred to the spouse.

6.3 Eligibility Renewal

Long Term Care provides twelve months of continuous coverage to eligible applicants. In order to continue Long Term Care coverage beyond twelve months, a re-evaluation of the Long Term Care categorical eligibility workflow and rules must be run, for the specific Long Term Care program that the individual is currently in receipt of. If eligibility is redetermined, eligible applicants can continue to receive Long Term Care for a subsequent twelve month period without any break in coverage.

The renewal month is the last month an enrollee is eligible to receive Long Term Care in a twelve month enrollment period, (last month of certification). In the month prior to the renewal month, notification is sent to the enrollee informing them that eligibility must be renewed. At certification renewal an individual is always treated as a single individual. A system task is generated for the case worker to renew the Long Term Care product delivery. To renew Long Term Care product delivery the caseworker selects the Renew link on the Long Term Care Product Delivery Home Page. A new product delivery is not created, the existing Long Term Care Product Delivery is re-certified.

During eligibility renewal only eligibility for the particular Long Term Care program that the individual is currently in receipt of is tested.

If the individual is determined eligible for continued Long Term Care coverage the caseworker can renew the existing product delivery. If an individual is determined ineligible for continued Long Term Care coverage a task is generated for the case worker to check eligibility for all medical assistance programs.

6.4 Manual Ownership Transfer Process

New functionality has been added for Long Term Care Medical Assistance to enable caseworkers to manually transfer ownership of resources from one individual to another individual or from an individual to a trust. With this functionality, case processing is used to determine correct ownership percentages, update old ownership records and generate new ownership records.

Ownership transfer evidence is required for enabling resource transfers in line with spousal impoverishment conditions as well as for determining sanctions for Long Term Care.

When a resource is recorded in the system, the case worker must add ownership records for each participant who has an ownership interest in the resource. When creating an ownership record, the system populates the new ownership record with values for resourceType and ItemType based on the

resource that the ownership record is linked to and calculates and stores the value of the resource owned by a participant based on their percentage ownership.

A household member may transfer their ownership of a resource to another individual. When the additional ownership transfer evidence is saved, the system updates the household member's ownership record with the transfer details and also creates new ownership record(s) to reflect the change of ownership for the household member and the recipient.

A household member may request to reverse a previous ownership transfer to an individual. The caseworker can reverse either all or a partial percentage of the original ownership transfer. If the percentage reversed is equal to or less than the amount owned by the recipient, the system updates the household member's ownership record with the transfer reversal details and creates new ownership records to reflect the change of ownership due to the transfer reversal. Note that a number of partial reversals can be processed up to the original percentage amount of the ownership transferred.

A household member may also transfer their current ownership of a resource to a Trust. The fair market value of ownership is calculated using the percentage owned by the household member and the fair market value of the resource. An ownership transfer to a trust cannot be reversed.

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