State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

CHRISTINE TODD WHITMAN
Governor

WILLIAM WALDMAN
Commissioner

VELVET G. MILLER
Director

MEDICAID COMMUNICATION NO. 95-11 **DATE:** July 3, 1995

TO: County Welfare Agency Directors
Institutional Services Section (ISS) Area Supervisors

SUBJECT: Medically Needy Long Term Care

As mentioned in Medicaid Communication No. 95-3, Governor Whitman's Fiscal Year 1996 budget contains language that provides that the medically needy component of New Jersey Care...Special Medicaid Programs be expanded to include long-term care services, effective July 1, 1995. At the same time, budget language also eliminates the traditional nursing home coverage available through the General Assistance (GA) program.

Effective immediately, in anticipation of legislation which authorizes this expansion, the county welfare agencies are instructed to begin accepting and processing new applications, including the conversion of GA long-term care cases. Instructions for processing medically needy coverage for long-term care are attached.

These cases will be assigned medically needy case numbers, i.e. Program Codes 15, 25, 35, 55, and the corresponding medically needy spenddown Program Status Code (PSC), i.e., 180, 280, 350, 370, 580. The non-spenddown PSCs do not apply in these cases. Also, a long-term care code for the medically needy long-term care screen is being developed for future on-line use. Until that code is available, the county welfare agencies should maintain a log of all long-term care cases accreted to the medically needy eligibility file.

Please be advised that for those GA cases being transferred to medically needy long-term care, the Bureau of Quality Control has advised that no errors will be charged to the county until after the first redetermination is completed.

Questions regarding this communication should be referred to field staff assigned to your county.

Sincerely,

Velvet G. Miller
Director

VGM:Jj
Attachment

c Karen Highsmith, Acting Director
Division of Family Development

Patricia Balasco-Barr, Director
Division of Youth and Family Services

MEDICALLY NEEDY COVERAGE FOR LONG TERM CARE

BACKGROUND: The State Budget for Fiscal Year 1996 contains language which provides for the expansion of Medicaid to include medically needy coverage for nursing home services. Concurrently, the Budget also contains language that eliminates the traditional nursing home coverage available through General Assistance. General Assistance coverage of these services will continue to be available only to persons who were receiving nursing home coverage through General Assistance for the month of June 1995 and who are residents in facilities which do not participate in Medicaid.

This extension of coverage for nursing home services does not extend to home and community based waiver programs operated by the Division. Eligibility for these waiver programs will continue to be limited by the Medicaid "cap." (As discussed below, effective July 1, 1995, qualified income trusts will no longer be valid in New Jersey. Therefore, eligibility for the home and community based waiver programs will be limited to persons whose income is less than or equal to the Medicaid "cap". Such trusts, if established prior to July 1, 1995 will continue to serve to exclude income in the determination of eligibility for the waiver programs).

While the medically needy segment does not provide for payment of pharmaceuticals for the aged, blind, or disabled, under federal statute, pharmaceutical services are included as a long term care service and, as such, will be available to persons eligible for medically needy coverage for long term care. System changes are being made to accommodate the inclusion of this service for persons eligible for medically needy long term care.

QUALIFIED INCOME TRUSTS ("MILLER TRUSTS"): In accordance with federal statute, qualified income trusts (commonly known as "Miller trusts") are recognized only in those states that do not provide medically needy coverage for nursing home services. Therefore, no new qualified income trusts established after June 30, 1995 will be recognized. This applies equally to persons receiving, or seeking to receive, nursing home services, as well as, home and community based waiver programs.

Qualified income trusts established prior to July 1, 1995 will continue to be in effect, and will continue to serve to exclude income in the income eligibility determination for Medicaid Only coverage for long term care and for the home and community care waiver programs.

RESOURCE ELIGIBILITY: In its existing medically needy program, New Jersey has opted to adopt a more liberal resource standard than that which applies in Medicaid Only.

These higher resource limits will apply equally to medically needy coverage for long term care. Therefore, the resource limit for an individual will be $4,000, and in the event that a couple is institutionalized in the same facility, the limit will be $6,000.

The spousal impoverishment provisions apply also to medically needy coverage for long term care. When determining eligibility for a married individual, the community spouse's protected resource level must be established. That level is the greater of $14,964 or one-half of the couple's countable resources not to exceed $74,820.

Income retained during a budget period shall not be considered a resource until the subsequent budget period.

Because the resource eligibility limit for medically needy is higher than the $2,000 limit employed in the Medicaid Only program, individuals paying privately and depleting their resources will achieve resource eligibility under medically needy before the Medicaid Only standard even if their income is below the Medicaid "cap". When such people contact the county welfare agency concerning Medicaid eligibility, they shall be advised that they may elect to spend their resources down to $4,000 and qualify for medically needy coverage or to spend their resources down to $2,000 to qualify for Medicaid Only benefits. The benefits of Medicaid eligibility shall be explained to such applicants including the coverage of inpatient hospital services and the other services available through Medicaid Only which are not available through medically needy coverage. They may also be advised that eligibility for full Medicaid Only is simpler for both the applicant and the agency. However, in no event, shall a county welfare agency imply that Medicaid Only is the only recourse for eligibility.

INCOME ELIGIBILITY: As with the existing medically needy coverage, eligibility for medically needy coverage for long term care is established through a spenddown process wherein medical bills are used to offset income.

Six-Month budget period: The budget period for persons whose income is such that they will qualify for medically needy based on projected institutional care expenses alone, shall be assigned a six-month budget period. The six-month budget period will begin on July 1, 1995 for all cases transferring from General Assistance to medically needy coverage under Medicaid. For new applicants, the six-month budget period will begin with the date of application.

As you may know, existing medically needy system requirements provide for automatic termination at the end of the six-month budget period. System modifications are being made to eliminate automatic termination for medically needy long term care cases.

One-month budget period: For persons who will not qualify for medically needy coverage for long term care based solely on projected institutional care expenses (actual incurred institutional and other medical expenses are needed to meet spenddown), a one-month budget period shall be assigned. Additional discussion concerning the one-month budget period appears below.

Retroactive budget period: The retroactive budget period shall be the three calendar-month period immediately preceding the date of application. There will be no retroactive coverage for any period prior to July 1, 1995. Each month of the retroactive period is calculated separately in determining eligibility.

Countable Income: Countable income shall be determined in the same manner as is determined for applicants and recipients of Medicaid Only - long term care except that the individual is entitled to the $20 general income disregard.

Spenddown liability: The amount by which countable income exceeds the medically needy income level (MNIL) for an individual for the entire budget period.

Medical expenses: In determining eligibility for medically needy - long term care, medical bills shall be applied in a strict chronological order based on the date of the service. They will not be sorted in the same manner that is used for persons applying for medically needy in the community. Health insurance premiums and Medicare premiums may not be projected. They shall be applied to spenddown in the beginning of the month that the premium is intended to cover.

Projection of Institutional Care Expenses: Institutional care expenses shall be projected for the entire budget period. The amount of the projected institutional care expense shall be based on the Medicaid reimbursement pay rate as reported by the facility. In developing the projected institutional care expenses for the budget period, the county welfare agency shall project the per diem on a 30-day month basis regardless of the actual number of days in the budget period.

In the event the individual's countable income is less than the institutional care expense, income eligibility is established. Because income eligibility is established based on the projected expenses, the county welfare agency does not need to track actual incurred medical expenses.

Likewise, when the individual has sufficient projected institutional expenses together with current liability for bills from a period prior to the current retroactive and prospective budget periods to meet spenddown liability for the budget period, the county welfare agency need not develop current actual incurred expenses.

Actual Incurred Institutional Care Expenses: Institutional care expenses cannot be projected at the private pay rate, only at the Medicaid rate. However, eligibility can be

established once the individual's actual institutional care expenses, together with other incurred medical bills, and remaining projected institutional care expenses reduce countable income to the MNIL for the budget period.

Date of Eligibility: Eligibility for medically needy benefits is established on the first day of the month in which allowable incurred medical expenses, together with projected institutional care expenses, equal the individual's spenddown liability. (Note: the effective date to be entered on the Medicaid Status File is the day after the day spenddown liability is met.) There are no split claims for long term care expenses. When long term care expenses are used to meet spenddown in a budget period, payment of long term care expenses by medically needy will begin on the day following the day that spenddown is met.

Projected Institutional Cost Exceeds Countable Income: When an individual's projected institutional care expenses exceed his or her countable income for the budget period, eligibility for medically needy exists without further evidence of medical expense liability. When projecting institutional care expenses, the county welfare agency shall compute the projection based on a 30-day month.

Monthly Income $1,500 - $20 (general disregard) = $1,480

$1,480 x 6 = $8,880 budget period income

MNIL $433 x 6 = $2,598 budget period MNIL

$8,880 - $2,598 = $6,282 spenddown liability

Medicaid per diem $90 x 30 = $2,700
$2,700 x 6 = $16,200 projected institutional care cost for budget period

Because the projected institutional care expenses for the budget period exceed the countable income for the budget period, medical expense liability clearly reduces income to below the MNIL.

Example: Mr. Kamp resides in a facility in which the Medicaid per diem is $90 (or $2,700 per month). His income is $2,600 per month.

Monthly income $2,600 - $20 = $2,580

$2,580 x 6 = $15,480 budget period income

MNIL $433 x 6 = $2,598 budget period MNIL

$15,480 - $2,598 = $12,882 spenddown liability

Medicaid per diem $90 x 30 = $2,700

$2,700 x 6 = $16,200 projected institutional care cost for budget period

Mr. Kamp's projected institutional care expenses for the budget period exceed his income for the budget period. He is, therefore, eligible for the medically needy program for the entire budget period.

Countable Income Exceeds the Medicaid Reimbursement Rate: When an individual's countable income for the budget period exceeds the projected institutional care expenses, the individual can still qualify if the projected institutional care expenses reduce income to the MNIL.

Example: Mr. Hand has monthly income of $3,200. The Medicaid per diem is $100 and the private pay rate is $120 per diem.

Monthly income $3,200 - $20 = $3,180

$3,180 x 6 = $19,080 budget period income

MNIL $433 x 6 = $2,598 budget period MNIL

$19,080 - $2,598 = $16,482 spenddown liability

Medicaid per diem $100 x 30 = $3,000

$3,000 x 6 = $18,000 projected institutional care cost for budget period

Mr. Hand is medically needy eligible because his projected institutional care expenses exceeds his spenddown liability for the six-month budget period.

Projected institutional care expenses can also be combined with previously incurred expenses to reduce income to the MNIL.

Example: Mr. Jobes has income of $3,800 monthly. The Medicaid reimbursement rate for his facility is $100 per diem. He has outstanding unpaid medical expenses of $2,500.

Monthly income $3,800 - $20 = $3,780

$3,780 x 6 = $22,680 budget period income

MNIL 433 x 6 = $2,598 budget period MNIL

$22,680 - $2,598 = $20,082 spenddown liability

Medicaid per diem $100 x 30 = $3,000

$3,000 x 6 = $18,000 projected institutional care cost for budget period

A portion of Mr. Jobes' outstanding medical bills can be used to meet spenddown.

Actual incurred expenses plus projected institutional expenses: When income is too high to qualify for medically needy on the basis of projected institutional care expenses alone, the individual can meet spenddown on the basis of incurred medical expenses, actual long term care expenses, and remaining projected institutional care expenses.

For any case not qualifying solely based on projected institutional care expenses, eligibility for medically needy will be based on a one-month budget period. As is expected in most cases, if the expenses used to meet spenddown liability in the one-month budget period are recurring (such as Medicare Part B premiums and actual and projected institutional care expenses), the county welfare agency may replicate that budget period for a six-month period. For instance, should an individual meet spenddown on the 17th of January based on the Part B premium and actual and projected institutional expenses, the county may assume that eligibility will exist on the 17th of the month for each month through June. The county would, of course, need to respond to reported income changes or reported medical expenses that would result in earlier eligibility than the 17th of the month.

Example: Ms. Wills resides in a facility in which the Medicaid per diem is $100. Her monthly income is $3,600.

Monthly income $3,600 - $20 = $3,580

- $433 MNIL

Spenddown liability $3,147

Medicaid per diem $100 X 30 = $3,000

Because Ms. Wills' spenddown liability exceeds her projected institutional care cost, she is not immediately eligible for medically needy coverage unless she has outstanding incurred medical expenses that may be applied toward spenddown.

Otherwise, medically needy eligibility will exist at the point she incurs actual institutional care expenses (at the private pay rate) together with other incurred medical expenses sufficient to meet her spenddown liability. Presuming a private per diem of $125 with no other incurred medical expenses, Ms. Wills meets spenddown liability on the 5th of the month.

Spenddown liability	$3,147.00
	- $ 46.10 Medicare Part B premium
Long term care liability	$3,100.90
Five days actual	5 x 125 = $625
Remaining projected for month	25 x 100 = $2,500
Total projected and actual expenses	$3,125

Ms. Wills would be accreted to the Medicaid Status file with an effective date of the 6th of the month. Medically needy would begin to pay for Ms. Wills' nursing home care beginning on the 6th.

Since Ms. Wills met spenddown with expenses that are expected to continue unchanged, the county welfare agency can project that she will achieve eligibility on the 6th of the month for the next five subsequent months.

POST-ELIGIBILITY TREATMENT OF INCOME

The post-eligibility treatment of income is, for most case situations, essentially identical to that employed in the Medicaid Only program. The individual is entitled to a personal needs allowance of $35. If applicable, provisions of the maintenance of a community spouse apply, as well as a deduction for a home for a temporary period.

Health insurance premiums are deducted in the same manner as in Medicaid Only. It is important to note that the medically needy program does not pay Medicare Part B premiums. Therefore, for persons enrolled in Medicare Part B, their premium deduction will appear on the PA-3L unless the premium was used to meet spenddown.

Federal regulations provide that, medical services that are not covered by the state plan are also deductible in the post eligibility treatment of income. Because full Medicaid paid virtually all medical services, this has not previously been an issue. However, because

medically needy provides a limited service package, there will be instances in which deduction for services not covered by medically needy will need to appear on the PA-3L form. Deductions for such medical expenses will be limited to those services occurring during a period of eligibility. (Deduction for expenses that were used to meet spenddown are not allowed in the post eligibility treatment of income.) Therefore, should a medically needy individual have a hospitalization, the expenses of that service would be deductible on the PA-3L because medically needy does not cover inpatient hospitalization. Only the client's actual liability for such a charge after Medicare or other third party payments have been made will be allowed.

Because income eligibility under the Medicaid "cap" has effectively limited the amount of income available to the community spouse, the Division has not previously imposed the federal maximum spousal maintenance allowance. Because under medically needy, institutionalized individuals will have higher income levels, the federal maximum is being imposed. The community spouse maintenance allowance, when combined with the excess shelter allowance cannot exceed $1,871. This maximum shall also apply in the Medicaid Only program.

For meeting spenddown liability with projected institutional expenses, the post eligibility treatment of income will, in most cases, be the same as for Medicaid Only cases.

Example: Mr. Kamp has a spouse in the community entitled to a $600 spousal maintenance allowance.

$2,600 PA-3L income

- $35 personal needs allowance

$2,565

- $600 community spouse maintenance allowance

$1,965.00

- $46.10 Medicare Part B premium

$1,918.90 income available for the cost of care

However, in instances in which the individual has spenddown to the MNIL, they may not have sufficient deductions in the post-eligibility treatment of income to reduce his or her income to the Medicaid reimbursement rate for the facility.

Example: Mr. Hand has no community spouse

$3,200 monthly income

- $35 personal needs allowance

$3,165.00

- $46.10 Medicare Part B premium

$3,118.90 income available for the cost of care

The Medicaid per diem for his facility is $100. Since his income exceeds the Medicaid reimbursement rate, Medicaid will not contribute to the cost of his long term care but will pay for other medically needy services. In completing the PA-3L for Mr. Hand, the county welfare agency will enter the Medicaid per diem as income available for the cost of care. While eligibility was based on a 30-day month, in completing the PA-3Ls for the budget period the county must enter the actual monthly reimbursement rate for the number of days in the month. Thus, in February, $2,800 would be available for the cost of care and in March $3,100 would be available for the cost of care. Mr. Hand's excess income is his discretionary income and he may use it as he desires.

For cases becoming eligible for medically needy based on actual incurred institutional care expenses, those actual institutional care expenses shall be deducted from gross income on the PA-3L for the initial month of eligibility. (In the post-eligibility treatment of income, income disregards used in the determination of income eligibility do not apply.)

Example: Ms. Wills has a community spouse who is entitled to $1,200 community spouse maintenance allowance. For the month of August in which she met spenddown on the 5th, she has actual incurred nursing home expenses of $625 plus the Medicare Part B premium of $46.10. On the PA-3L for the month of August her income will be:

$3,600.00 gross countable income

- $671.10 actual incurred institutional care cost plus Medicare Part B

$2,928.90 income

Ms. Wills would be entitled to a personal needs allowance and the community spouse maintenance allowance. Remaining income would be used to offset the

cost of her care. (Note: Ms. Wills' Medicare Part B premium will not appear on the PA-3L because it was used to meet her spenddown liability.)

$2,928.90 PA-3L income

-$ 35 personal needs allowance

$2,893.90

-$1,200 community spouse maintenance allowance

$1,693.90 income available for cost of care

On the PA-3L, $1,693.90 would be indicated as available for the cost of care. In this instance a PA-3L for a six-month period would be completed because no change in the income available for the cost of care is anticipated.

If, however Ms. Wills' income in the post eligibility treatment of income was not reduced by the community spouse maintenance allowance, her income available for the cost of care would exceed Medicaid's liability for the cost of her care. An instance such as this requires additional development.

While eligibility determinations are made on the basis of 30-day months when determining spenddown eligibility, when income available for the cost of care exceeds Medicaid's liability, the number of days in the month must be considered to determine the actual client contribution to the cost of care.

Without a community spouse maintenance allowance, Ms. Wills' income available for the cost of care is as follows:

$2,950 PA-3L income

- 35 Personal needs allowance

$2,915 available for the cost of care

In determining her eligibility, there were 25 days of projected expenses at the Medicaid rate, however, August has 31 days. Therefore Medicaid's reimbursement to the facility for August would be based on 26 days (26 x $100 = $2,600).

Because Ms. Wills' amount available for the cost of care exceeds Medicaid's liability the amount of Medicaid's liability is the figure entered as gross income on the PA-3L. Since Medicaid's liability is offset by Ms. Wills' income, Medicaid will

not be paying for her long term care expenses but will be paying for other medically needy services.

Ms. Wills' excess income ($2,915 - $2,600 = $315) is her discretionary funds which she may use as she desires.

CASES TRANSFERRING FROM GENERAL ASSISTANCE

CERTIFICATION IN LIEU OF APPLICATION: For those cases being transferred from the municipal welfare agencies, the county welfare agency shall complete a certification in lieu of application (copy attached) and file it in the case record. An application for Medicaid shall be completed at the next redetermination of eligibility.

REDETERMINATION DATES: In order to assist the county welfare agencies in equalizing their workload, for cases transferring from General Assistance, the county welfare agency may assign budget periods of less than six months initially. Shortened budget periods may only be assigned to cases eligible immediately eligible for medically needy immediately eligible based on projected institutional care expenses. Cases which will not attain eligibility immediately because spenddown is not yet met, shall be assigned a budget period of six months. These shortened budget periods apply only to current General Assistance cases and apply only to the initial determination for eligibility for medically needy.

PREADMISSION SCREENING: Long term care facilities are being advised to submit Form MCNH-33 to the Medicaid District Office (MDO) for their existing General Assistance caseload. The MDO will, in turn, do an abbreviated Preadmission Screening (PAS) for the institutionalized individual. In the event the county welfare agency is processing medically needy eligibility for an individual for whom there has not yet been a PAS, the county welfare agency shall notify the long term care facility so that a Form MCNH-33 can be initiated.

PRESUMPTION OF CERTAIN FACTORS: For individuals eligible for General Assistance coverage of long term care in the month of June 1995 and transferring to the county welfare agencies for eligibility under medically needy, certain factors relating to eligibility will be presumed to have been met and, therefore, the county welfare agency need not pursue or require documentation.

Disability/Age - it shall be presumed that the individual is either aged or disabled. Approval of the disability review team shall not be required nor shall the county welfare agency require proof of age if it is not available from the municipality.

Citizenship - U.S. citizenship shall be presumed.

Resources/Income - Income and resources as reported by the General Assistance agency shall be presumed to be correct until the case is subject to redetermination. Resource eligibility for medically needy long term care for current General Assistance recipients shall be determined without regard to the resources of the community spouse.

Resource Transfer - Because no General Assistance recipient could have transferred assets with the intent to qualify for Medicaid, the county welfare agency shall not develop issues relating to resource transfer.

COMMUNITY SPOUSE INCOME MAINTENANCE ALLOWANCE: Should an individual converting from General Assistance to medically needy coverage for long term care have a spouse in the community, the county welfare agency shall contact the community spouse to develop the entitlement to the allowance. However, in no event shall the development of the community spouse maintenance allowance delay the accretion on the institutionalized individual to medically needy eligibility. When established, the community spouse maintenance allowance shall have an effective date of July 1, 1995.

_____ COUNTY WELFARE AGENCY

CERTIFICATION IN LIEU OF APPLICATION FOR MEDICALLY NEEDY

LONG TERM CARE

This certification form provides for administrative action in lieu of an application for medically needy eligibility for long term care services under the Medicaid Program. It shall be used only form persons who are eligible for long term care services under General Assistance for the month of June 1995.

Case Name _____ Case Number _____
(Last) (First) (Initial)

Nursing Home Social Security Number _____

_____ Registration Date _____

_____

It is hereby certified that the above named individual has been evaluated as eligible for medically needy long term care services under Medicaid effective July 1, 1995.

_____ _____
Signature of Certifying Person Date

_____
Title of Certifying Person

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