Chapter 24

Long Term Care

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
24.1				
24.2				
24.3				
24.4	4/1/18	755	24.4.1.C.11	Reflect the December 2017 change in the way Medical ID cards are issued.
			24.4.2	Clarified the current policy regarding the redetermination process.
			24.4.3	Changed title to Special Procedures Related to Application and Redetermination Processing
	4/1/20	784	24.4.1.C.1	Changed inROADS to WV Path
24.5				
24.6				
24.7	7/1/18	761	24.7.7	All appropriate material and examples were changed to reflect the updated SMS and FMA amounts.
	3/1/19	769	24.7.7	Updated SMS figures.
	7/1/19	773	24.7.7	Updated SMS figures.
24.8	1/1/18	749	24.8.2.B.3	Adding new policy to existing text that the individual can establish their own trust on or after December 13, 2016.
	1/1/18	750	24.8.1.B	New SSI amounts

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	4/1/18	755	24.8.2.E.1	Added a “Note” regarding the current requirement to send a copy of an annuity to the Estate Recovery vendor
			24.8.2.D.1, 24.8.2.H, 24.8.2.J.1 24.8.2.J.2	Change numbers related to the State’s average monthly nursing private pay rate for the calculation of transfer penalty lengths
	8/1/18	762	24.8.2.B.4	Update transfer policy to disallow penalty adjustments for partial returns of assets.
	10/1/18	765	24.8.2.D.1 24.8.2.H 24.8.2.J	Changed numbers related to the State’s average monthly nursing facility private pay rate for the calculation of transfer penalty lengths
	1/1/19	768	24.8.1.B 24.8.4	New SSI amounts
	10/1/19	778	24.8.2.D.1, 24.8.2.H, 24.8.2.J.1, 24.8.2.J.2	Updated the dollar amounts related to the State’s average monthly nursing facility private pay rate for the calculation of transfer penalty lengths.
	1/1/20	780	24.8.1.B 24.8.4	Minimum community spouse asset limit increased Home Equity asset limit increased
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24.1 INTRODUCTION

This chapter describes the Department of Health and Human Resources' (DHHR) policies and procedures related to eligibility for long term care (LTC). LTC includes both institutional care and non-institutional home and community-based services (HCBS).

- Institutional care includes nursing facilities (NF) and intermediate care facilities for individuals with intellectual disabilities (ICF/IID).
- West Virginia's HCBS include four programs. These are for people who would otherwise need institutional level of care, but have chosen to receive care in the community.

  West Virginia has been granted waivers by the Centers for Medicare and Medicaid Services (CMS) to provide HCBS to several target populations:

  - Aged or disabled people under the Aged and Disabled Waiver (ADW)
  - Intellectually or developmentally disabled individuals under the Intellectual Disabilities and Developmental Disabilities (I/DD) Waiver
  - Individuals with traumatic brain injury under the Traumatic Brain Injury (TBI) Waiver

  Additionally, West Virginia has opted to implement the Children with Disabilities Community Services Program (CDCSP) eligibility category, which allows for children who would otherwise need an institutional level of care to receive services in the community.

This chapter covers policies relating to individuals in two different situations:

- Clients who are already enrolled in or eligible for Medicaid who have a new need for LTC.
- Applicants who were not eligible for Medicaid at the time of application, but who may have become eligible because of their need for LTC.

All LTC programs require a determination of medical eligibility, as well as a determination of financial eligibility conducted by the Worker.

This chapter also sets out policies and procedures for determining if clients found eligible for institutional care must contribute to their cost of care.

This chapter is organized as follows:

- Section 24.1 – 24.3 applies to all LTC programs.
- Sections 24.4 – 24.15 cover information related to Nursing Facility services.
- Sections 24.16 – 24.27 cover information related to ICF/IID services.
- Sections 24.28 – 24.36 cover information common to the HCBS programs.
- Sections 24.37 – 24.40 provide information about the ADW.

- Sections 24.41 – 24.44 provide information about the I/DD waiver.
- Sections 24.45 – 24.48 provide information about the TBI waiver.
- Sections 24.49 – 24.58 provide information about CDCSP.

24.1.1 INFORMATION PROVIDED TO THE CLIENT

In determining eligibility for payment of LTC, the Worker must ensure that the client, or his authorized representative, is fully informed of the policies and procedures. This is necessary so that the client, his family, or his authorized representative is able to make informed decisions about the client's financial affairs. A face-to-face interview is not required, but there may be circumstances where the Worker may need to contact a client.

The applicant may designate an authorized representative to act on his behalf. Such a designation must be in writing and include the applicant's signature. See Section 24.4.1.C.5 for more information about authorized representatives.

When an applicant's medical eligibility for, or enrollment in, LTC programs is pending due to a waitlist for services or another reason, he must still be allowed to apply and must be evaluated for any or all assistance programs.

The Worker must not, under any circumstances, suggest or require that the client or authorized representative take any specific action in financial matters. The Worker must not act as a financial planner or make suggestions about the client's current or future financial actions, including those that could affect estate recovery. The Worker may respond to general estate recovery questions, but must refer the client or his authorized representative to the Bureau for Medical Services (BMS) or its contract agency for specific information. The Worker must not contact the BMS or their contract agency on behalf of the client, but must refer the client or authorized representative to the BMS contract agencies listed in Appendix E.

24.1.2 INQUIRIES FROM PROVIDERS AND STAFF

The Worker must refer all inquiries about billing issues from the nursing or ICF/IID facility to the BMS contract agency listed in Appendix E. The Worker must not contact BMS on behalf of the provider.

Questions from county staff about any aspect of LTC cases must be directed to BMS Medicaid Eligibility Policy Unit.

24.2 VERIFICATION

Routine verification requirements are outlined in Chapter 7. Additional verification requirements for long term care services are included in this chapter.

For Intellectual and Developmental Disabilities (I/DD) waiver services, follow the instructions for Supplemental Security Income (SSI)-Related Medicaid in Chapter 7.

24.3 RESOURCE DEVELOPMENT

When Medicaid eligibility is established, clients are required to retain or develop resources that can reduce Medicaid costs. See Chapter 8.

NURSING FACILITY SERVICES

24.4 APPLICATION/REDETERMINATION

Payment for nursing facility care is a service available to eligible Medicaid clients. Eligibility for payment for nursing facility services is determined in any of the following four ways, in priority order; also see Section 24.7.2.

1. Qualified Medicare Beneficiary (QMB) clients, when Medicare is participating in the nursing facility payment, or will participate when the client enters the nursing facility.
2. Full coverage Medicaid clients.
3. Nursing Facility coverage group – nursing facility residents who meet a special income test.
4. Supplemental Security Income (SSI)-Related/Monthly Spenddown – when the monthly Medicaid rate for the facility in which the client resides equals or exceeds his monthly spenddown amount, the spenddown is assumed to be met and Medicaid eligibility is established.

24.4.1 THE APPLICATION PROCESS

24.4.1.A QMB Clients

When a client needs nursing facility services and Medicare participates in payment, it may be to the client's advantage to receive payment for nursing facility services as a QMB-eligible until Medicare no longer participates. See Section 24.7.2 for additional information.

See Chapter 1 for the application process for QMB.

24.4.1.B Full Coverage Medicaid Clients

When the individual is a client under a coverage group which provides full Medicaid coverage at the time he is determined to need nursing facility services, his Medicaid eligibility has already been determined; however, the transfer of resources, trusts and annuities provisions outlined in

Section 24.8 apply. These additional eligibility requirements for payment of nursing facility services apply to all Medicaid clients, including SSI, Deemed SSI, and Modified Adjusted Gross Income (MAGI) coverage group clients, and require the client to submit an additional application form for payment of nursing facility services.

24.4.1.B.1 Application Form

All full coverage Medicaid clients who need Medicaid payment for nursing facility services must complete and return the Application for Long Term Care Services for Current Medicaid Recipients (DFA-LTC-5), at the initial application for nursing facility services. The DFA-LTC-5 is used to evaluate annuities, trusts, and resource transfers to determine if a transfer penalty applies.

24.4.1.B.2 Date of Application

The date of application for payment of nursing facility services for current Medicaid clients is the date the applicant submits a DFA-LTC-5 in person, by electronic transmission, or by mail, which contains, at a minimum, his name, address, and signature. Payment for nursing facility services is not approved until the DFA-LTC-5 form is completed, signed, and returned to the local office.

24.4.1.B.3 SSI and Deemed SSI

SSI and Deemed SSI Medicaid clients who need Medicaid payment for nursing facility services must complete the DFA-LTC-5 application form at initial application and annual redetermination. SSI and Deemed SSI clients were determined asset eligible for Medicaid by the Social Security Administration (SSA), however, the client must disclose information about transfer of resources, trusts, and annuities. Payment for nursing facility services is not approved until the DFA-LTC-5 form is completed, signed, and returned to the local office.

When the DFA-LTC-5 form is not returned at the annual redetermination, the payment for long term care (LTC) services is closed after advance notice.

24.4.1.C Nursing Facility Coverage Group and SSI-Related/Monthly Spenddown Group

If the applicant is currently residing in the nursing facility, is not eligible as a QMB client, and is not eligible to receive full coverage Medicaid without a spenddown, he must apply for Medicaid eligibility in the Nursing Facility coverage group or SSI-Related/Monthly Spenddown group.

24.4.1.C.1 Application Forms

The following application forms may be used:

- DFA-2;
- WV PATH;
- DFA-MA-1, Application for Long Term Medicaid and Children with Disabilities Community Service Program; or
- DFA-SLA-1 or DFA-SLA-2, Single-Streamlined Application (SLA) with supplement DFA-SLA-S1.

The DFA-RR-1 is required with the DFA-2.

24.4.1.C.2 Complete Application

The application is complete when the client or his authorized representative signs a DFA-2, WV PATH application, DFA-5, DFA-MA-1, or SLA which contains, at a minimum, the client's name and address.

24.4.1.C.3 Date of Application

The date of application is the date the applicant submits a DFA-2, WV PATH application, DFA-MA-1, or SLA, in person, by electronic transmission, or by mail, which contains, at a minimum, his name, address, and signature. When the application is submitted by mail or fax, the date of application is the date that the form with the name, address, and signature is received in the local office.

NOTE: When the applicant has completed the interactive interview, and there is a technical failure that prevents the printing of the DFA-2, Form DFA-5 must be signed by the applicant, attached and filed in the case record with the subsequently printed DFA-2. The DFA-RR-1 must also be completed when the DFA-5 has been signed.

If a Medicaid client loses eligibility and does not receive payment for nursing facility services for one month, he must reapply and is subject to the current application requirements unless the loss of eligibility or payment was due to a delay or error caused by the Department of Health and Human Resources (DHHR).

If an individual transfers to a nursing facility in West Virginia, he must submit an application and his eligibility must be evaluated as any other applicant.

24.4.1.C.4 Interview Required

No interview is required.

24.4.1.C.5 Who Must Sign

The application must be signed by the applicant, the spouse, or the authorized representative. When the applicant is a child under age 18, the parent(s) or legal guardian must sign.

- ***Authorized Representatives***

The applicant may designate an authorized representative to act on his behalf. Such a designation must be in writing and include the applicant's signature.

Authority for an individual or entity to act on behalf of an applicant or beneficiary accorded under state law, including but not limited to, a court order establishing legal guardianship or a power of attorney, must be treated as a written designation by the applicant or beneficiary of authorized representation.

The power to act as an authorized representative is valid until the applicant or beneficiary modifies the authorization to the DHHR.

The authorized representative is responsible to the same extent as the client being represented, including confidentially of any information regarding the client provided by the agency and agreeing to the terms of the Rights and Responsibilities.

Examples of documents the applicant may submit with the Medicaid application to verify he has designated an authorized representative include, but are not limited to:

- Single Streamlined Application (DFA-SLA-1, Appendix C)
- Application for Long Term Care Medicaid and Children with Disabilities Community Service Program (DFA-MA-1)
- Durable power of attorney (POA) and/or medical power of attorney documentation, unless limited in scope
- Court orders designating a guardian or conservator (signed by court)
- Healthcare surrogate documentation for an incapacitated applicant (signed by physician and surrogate)

24.4.1.C.6 Agency Time Limits

The Worker must give the applicant at least 10 days for any requested information to be returned.

The Worker must take eligibility system action to approve, deny, or withdraw the application within 30 days of the date of application.

24.4.1.C.7 Agency Delays

If the DHHR failed to request necessary verification, the Worker must immediately send a verification checklist or form DFA-6 and DFA-6a, if applicable, to the client and note that the application is being held pending. When the information is received, benefits are retroactive to the date eligibility would have been established had the DHHR acted in a timely manner.

If the DHHR simply failed to act promptly on the information already received, benefits are retroactive to the date eligibility would have been established had the DHHR acted in a timely manner.

For these cases, timely processing may mean acting faster than the maximum allowable time. If an application has not been acted on within a reasonable period of time and the delay is not due

to factors beyond the control of the DHHR, the client is eligible to receive direct reimbursement for out-of-pocket medical expenses. See Chapter 10.

24.4.1.C.8 Payee

The client is the payee.

24.4.1.C.9 Repayment and Penalties

This does not apply to the Nursing Facility coverage group and SSI-Related/Monthly Spenddown Medicaid.

24.4.1.C.10 Beginning Date of Eligibility

➢ *Medicaid Eligibility*

Medicaid eligibility begins on the first day of the month in which eligibility is established. Eligibility may be backdated up to three months prior to the month of application, when all eligibility requirements were met, and the client has medical expenses for which he seeks payment.

➢ *Payment for Nursing Facility Services*

Payment for nursing facility services begins on the earliest date the three conditions described below are met simultaneously. Payment for nursing facility services may be backdated up to three months prior to the month of application when all the conditions described below are met for that period.

- The client is eligible for Medicaid; and
- The client resides in a Medicaid-certified nursing facility; and
- There is a valid pre-admission screening (PAS) or, for backdating purposes only, physician's progress notes or orders in the client's medical records. Section 24.12 contains information about the PAS and details specific situations in which the progress notes or orders are used.

➢ *Examples*

Expired PAS Example: Mr. Birch is a patient in a hospital. The physician recommends nursing facility care to Mr. Birch's family and completes a PAS dated June 5, 2016. The family is undecided about placing Mr. Birch in a nursing facility and takes him home to provide care. They do not apply for Medicaid until August 16, 2016, which is the date Mr. Birch enters the nursing facility. Medicaid eligibility is established beginning August 1, 2016. The original PAS has expired. A new PAS is not completed until August 22, 2016. The Worker can request the physician's notes to verify Mr. Birch's medical necessity from August 16, 2016, through August 22, 2016. Medicaid nursing care payments begin August 16, 2016 using physician's notes.

Delayed Entry Example: Same situation as above except that the PAS is dated June 25, 2016. A new PAS is not required, but nursing facility payments cannot begin until August 16, 2016, which is the date Mr. Birch entered the nursing facility.

Excess Assets Example: Ms. Dahlia enters a nursing facility on August 16, 2016, and the PAS is signed August 16, 2016. However, she does not become Medicaid eligible until September 1, 2016, due to excess assets. Payment for nursing facility services begins September 1, 2016.

Backdating Example: Mr. Pine enters a nursing facility on October 10, 2016, and a PAS is signed on that date. On November 25, 2016, his family applies for Medicaid to pay for his nursing care costs. Medicaid eligibility is backdated to August 1, 2016, to cover the cost of his recent hospitalization. Payment for nursing facility services begins on October 10, 2016.

24.4.1.C.11 The Benefit

A Medical ID card is issued for each eligible individual.

➢ *Ongoing Benefits*

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

- ***Ending Date of Eligibility***

The ending date of eligibility is the last day of the month of the effective month of closure.

24.4.2 REDETERMINATION PROCESS

Redeterminations are completed annually, and no interview is required. The eligibility system alerts the Worker when a redetermination is due and automatically sends a redetermination form to the client.

The redetermination may be completed by the client or his authorized representative.

24.4.3 SPECIAL PROCEDURES RELATED TO APPLICATION AND REDETERMINATION PROCESSING

24.4.3.A Authorized Representative Resides in Another State

If the authorized representative does not reside within the state of West Virginia, he may submit any required documentation electronically, or by mail, to the appropriate Worker in the appropriate county office. The authorized representative may also ask a nursing facility staff member who has knowledge of the client's financial circumstances to communicate with the Department and submit documentation on the client's behalf. However, applications and redeterminations must still be signed by the applicant, the spouse or the authorized representative.

24.4.3.B Authorized Representative Resides in Another County

When the authorized representative resides in another county, he may submit any required documentation electronically, or by mail, to the Worker in the county responsible for the case. The authorized representative may also choose to communicate with and submit documentation to the Department in his own county of residence. In this situation, the county receiving the documentation should forward it securely to the county responsible for the case the same day it is received.

24.4.3.C Correct County of Residence for Nursing Facility Applicants

Nursing facility residents are considered to reside in the county where the nursing facility is located. However, there may be instances when the client applies before entering the nursing facility.

The county in which the individual resides on the date of application will accept responsibility for processing the application.

- When the applicant resides in a nursing facility at the time of application, the county where the facility is located accepts responsibility for processing the application.
- When the applicant still resides in their home county at the time of application, the current county of residence accepts responsibility for processing the application. Once eligibility has been determined, the case and record should be transferred to the county of the nursing facility.

The county responsible for the application responds to all inquiries related to the application until an eligibility decision is determined. Once the application process is complete and eligibility is determined, the case is housed in the county of the nursing facility.

24.5 COMMON ELIGIBILITY REQUIREMENTS

Individuals receiving payment for nursing facility services must meet all common eligibility requirements in Chapter 2. This section contains additional residency requirements for nursing facility eligibility.

The client meets the residency requirement when he is living in, not visiting, West Virginia with the intention of remaining permanently or for an indefinite period.

24.5.1 EXPRESSION OF INTENT TO LIVE IN WEST VIRGINIA

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

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

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

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

24.5.2 MINORS

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

24.5.3 PLACEMENT BY OUT OF STATE AGENCY

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

24.6 ELIGIBILTY DETERMINATION GROUPS

Eligibility may be determined under any full Medicaid coverage group using the eligibility determination groups for the appropriate coverage group. See Section 24.7.2 and Chapter 3. If the client is not eligible for a full Medicaid coverage group, the client is assessed for eligibility under the Nursing Facility coverage group and the SSI-Related/Monthly Spenddown group using the following guidance.

24.6.1 THE ASSISTANCE GROUP (AG)

Only the institutionalized individual is included. A Medicaid-eligible spouse must be in his own AG, whether he is also institutionalized or not.

24.6.2 THE INCOME GROUP (IG)

Only the countable income of the institutionalized individual is used to determine his eligibility.

24.6.3 THE NEEDS GROUP (NG)

The NG is composed only of the institutionalized individual. See Section 24.7 for applicable income standards.

24.6.4 CASE COMPOSITION

The case is composed of the institutionalized individual, a spouse living in the community, and any of the individual's dependents. A Medicaid-eligible spouse receives benefits in his own case, whether he is also institutionalized or not.

24.7 INCOME FOR ELIGIBILITY DETERMINATION

There is a two-step income process for providing Medicaid coverage for nursing facility services to individuals in nursing facilities. The client must be eligible for Medicaid and there must be a determination to see if the client must contribute to the cost of care.

Medicaid eligibility can be established by virtue of being a Qualified Medicare Beneficiary (QMB) client, of being a member of a full Medicaid coverage group, by meeting a special income test for the nursing facility coverage group, or by meeting a SSI-Related/Monthly Spenddown. See Chapter 23 to determine which coverage groups provide full coverage Medicaid.

Once Medicaid eligibility is established, if applicable, the client's contribution toward his cost of care in the facility is determined in the post-eligibility process. The post-eligibility process is described in Section 24.7.3 below.

24.7.1 BUDGETING METHOD

See Section 4.6 for generally applicable information about determining income. Monthly income is determined based on averaging income over multiple months, if applicable, and converting or prorating income for time periods other than monthly from each source.

For each month of residence in a facility, all countable income must be used in determining eligibility and in post-eligibility calculations, even if he resides only one day in the facility. No deductions or exclusions are allowed for income already spent in the month the client enters the nursing facility or for expenses he anticipates in the month he leaves.

24.7.2 FINANCIAL ELIGIBILITY PROCESS

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

24.7.2.A QMB Clients

When a client needs nursing facility services and Medicare is participating in the payment or will participate when the client enters the nursing facility, it may be to the client's advantage to

receive payment for nursing facility services as a QMB-eligible, until Medicare no longer participates. QMB covers all Medicare co-insurance and deductibles. QMB clients are exempt by law from the post-eligibility process and, therefore, have no contribution toward their cost of nursing facility services, as long as Medicare participates in the payment. See Chapter 23.

However, the Worker must use one of the following ways to determine eligibility, if it would be more beneficial to him than QMB. In addition, when Medicare stops participating in the cost of care, QMB eligibility no longer covers nursing care costs and eligibility must be redetermined according to the options below.

24.7.2.B Full Coverage Medicaid Clients

When the individual is a client under a coverage group that provides full coverage Medicaid at the time he is determined to need nursing facility services, his Medicaid eligibility has already been determined.

For all full coverage groups, the client must complete the Application for Long Term Care Services for Current Medicaid Clients (DFA-LTC-5) at application for LTC services to evaluate any annuities, trusts and/or other potential resources or transfers so the Worker can determine if there will be a penalty period. See Section 24.8.

All Medicaid coverage groups listed in Chapter 23 are full Medicaid coverage groups, unless there is a statement specifically to the contrary.

SSI-Related or AFDC-Related individuals who are required to meet a six month spenddown must have previously met their spenddown to be determined eligible under this provision.

Those SSI-Related or AFDC-Related individuals who have no spenddown are Medicaid eligible. Those who meet their spenddowns prior to the need for nursing facility care have met the requirement to be eligible, through the current period of eligibility (POE). After the POE during which nursing facility services begin, the client's eligibility is reviewed according to Section 24.7.2.C or Section 24.7.2.D below. Those who do not meet their spenddowns prior to the need for nursing facility care are reviewed for eligibility according to the two options described in Section 24.7.2.C and Section 24.7.2.D below.

These clients' contribution toward cost of care is determined in the post-eligibility process. There are no post-eligibility calculations for Modified Adjusted Gross Income (MAGI) coverage groups.

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

24.7.2.C Nursing Facility Coverage Group, Gross Income Test

If the client is not currently eligible by having QMB or full coverage Medicaid, Medicaid eligibility may be established as follows:

- If the client's gross countable monthly income is equal to or less than 300% of the current maximum Supplemental Security Income (SSI) payment for one person and the client is institutionalized, he may be eligible.
- SSI-Related Categorical Medicaid requirements (aged, blind or disabled) and asset guidelines must be met.

These clients' contribution toward cost of care is determined in the post-eligibility process. There is no spenddown amount for these clients.

24.7.2.D SSI-Related / Monthly Spenddown

If the client is not otherwise eligible by having QMB, full coverage Medicaid, or Nursing Facility coverage group, his eligibility as an SSI-Related Medicaid client with a monthly spenddown must be explored. All policies and procedures in effect for other SSI-Related cases apply to these cases, including the determination of a spenddown amount.

EXCEPTIONS:

- *Income is not deemed.*
- *The Medically Needy Income Level (MNIL) for one person is always used. See Chapter 4, Appendix A.*
- *The spenddown amount is a monthly period of consideration, rather than a six-month period.*

24.7.2.D.1 Spenddown Calculation

When the monthly Medicaid rate for the facility in which the client resides equals or exceeds his monthly spenddown amount, the spenddown is assumed to be met and Medicaid eligibility is established.

If the monthly spenddown amount exceeds the monthly Medicaid rate for the facility, the client may become eligible for Medicaid based on a six-month period of consideration (POC), but not for payment of nursing facility services.

The Medicaid daily rate for the facility is multiplied by 30 to determine the average monthly rate. The daily rates are found only on the Division of Family Assistance (DFA) intranet page. The rates are updated at least semi-annually. Any requests for the rates must be made under the Freedom of Information Act (FOIA) to the Department of Health and Human Resources (DHHR) Office of the Deputy Secretary, Division of Accountability and Management Reporting.

Case examples of the entire process of determining eligibility and the amount of the client's contribution are found below in Section 24.7.7.

24.7.3 POST-ELIGIBILITY PROCESS

The post-eligibility process does not apply to the MAGI Medicaid coverage groups – Adult Group, Parents/Caretaker Relatives, Pregnant Women, Children Under Age 19, or certain QMB clients. MAGI Medicaid coverage groups and QMB clients for whom Medicare pays a full month do not contribute to the cost of their nursing facility care.

Income sources that are excluded for the coverage group under which eligibility is determined are also excluded in the post-eligibility process for nursing facility services. See Section 4.3 for excluded sources for the appropriate coverage group.

In determining the client's contribution toward his cost of nursing facility care, the Worker must apply only the income deductions listed below. This is the post-eligibility process. The remainder, after all allowable deductions, is the resource amount, which is at least part of the amount the client must contribute toward his cost of care.

The client's spenddown amount, if any, as determined above, is added to the resource amount to determine the client's total contribution toward his nursing care, except when there is a community spouse. In cases with a community spouse, the spenddown is not added to the computed resource amount. The spenddown is used only to compare to the nursing facility’s Medicaid cost of care to determine eligibility. See Section 24.7.6.

24.7.3.A Income Disregards and Deductions

Only the items in the following sections may be deducted from the client's gross income in the post-eligibility process.

24.7.3.A.1 Client's Personal Needs Allowance (PNA)

This amount is subtracted from income to cover the cost of clothing and other personal needs of the nursing facility resident. For most residents, the monthly amount deducted is $50. However, for an individual who is receiving the reduced Veterans Affairs (VA) pension of $90, the monthly PNA is $90. Similarly, an individual receiving SSI will have his monthly allocation reduced to $30, which is his monthly PNA if he is in the facility for at least three months.

24.7.3.A.2 Community Spouse Maintenance Allowance (CSMA)

When the institutionalized individual has a spouse living in the community, a portion of his income may be deducted for the support of the spouse at home. The community spouse must be included as part of the case and his living expenses taken into consideration to calculate the CSMA.

To determine the CSMA, the income of the community spouse is subtracted from a Spousal Maintenance Standard (SMS) which is either:

- The minimum SMS. This is 150% of the monthly FPL for 2 persons; or
- The minimum SMS, increased by excess shelter/utility expenses, but not exceeding the maximum SMS.

See Chapter 4, Appendix A for the minimum and maximum Spousal Maintenance Standard amounts.

The remainder is the amount of the institutionalized spouse's income which can be used to meet his community spouse's needs.

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

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

Step 1: Add the actual shelter cost and the amount of the current SNAP Heating/Cooling Standard (HCS). See Chapter 4, Appendix B. The shelter cost must be for the home the institutionalized spouse and the community spouse shared prior to institutionalization, and in which the community spouse continues to live. It must have been the client's principal place of residence. Shelter costs include rent or mortgage payments, interest, principal, taxes, insurance and required maintenance charges for a condominium or cooperative.

Step 2: Compare the total of the costs in Step 1 to 30% of the minimum SMS. See Chapter 4, Appendix A. When the shelter/utility costs exceed 30% of the minimum SMS, subtract the 30% amount from the shelter/utility costs.

Step 3: Add the remainder from Step 2 to the minimum SMS. This amount, not to exceed the maximum SMS, is used in Step 5. See Chapter 4, Appendix A.

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

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

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

If the calculated CMSA is less than the minimum SMS or the Community Spouse will experience extreme financial duress, a fair hearing can be requested by the client, community spouse or authorized representative to obtain more of the institutionalized spouse's income and/or assets. See Common Chapters Manual, Chapter 700, Section 710.27.

24.7.3.A.3 Family Maintenance Allowance (FMA)

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

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

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

Step 1: Subtract the family member's total gross countable income from the minimum SMS. See Chapter 4, Appendix A. If the income is greater than the minimum SMS, no deduction is allowed for that member.

Step 2: Divide the remaining amount by 3, and round the resulting amount up. This calculation ensures the FMA for each family member will not exceed one-third of the minimum SMS. See Chapter 4, Appendix A.

> **Rounding Example:** $201.07 = $202

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

24.7.3.A.4 Outside Living Expenses (OLE)

Single individuals and couples, when both spouses are institutionalized, receive a $175 deduction from income for maintenance of a home when a physician has certified in writing that the individual, or in the case of a couple, either individual, is likely to return to the home within six months. The amount may be deducted for up to six months.

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

The OLE may be deducted during subsequent nursing facility admissions if the individual or couple meets the criteria listed above.

> **OLE Example:** Ms. Rose is admitted to a nursing facility for six months and then discharged to her home. Her condition worsens after four months and she is readmitted to the nursing facility again. She can receive the OLE again, if her physician certifies she is likely to return home again within six months.

24.7.3.A.5 Non-Reimbursable Medical Expenses (NRME)

Certain non-reimbursable medical expenses for the eligible client only may be deducted in the post-eligibility process. These expenses are sometimes referred to as “remedial expenses.”

Non-reimbursable means the expense will not be or has not been paid to the provider or reimbursed to the client by any third-party payer, such as, but not limited to, Medicare, Medicaid, private insurance or another individual.

These allowable expenses are listed in Section 4.14.4.J.3. Incurred medical expenses, including nursing facility costs (except for nursing facility costs for clients with a community spouse), for which the client will not be reimbursed, are subtracted from his remaining income.

When the client becomes eligible for nursing facility services after expiration of a penalty period for transferring resources, nursing facility expenses incurred during the penalty period which are non- reimbursable from another source may be used as a deduction.

➢ *Deductible Premiums*

Deductible premiums include any portion of the Medicare Part D Premium that is not covered by the Low Income Subsidy (LIS). The incurred expense must be the responsibility of the client.

The total deduction for medical insurance premiums is given to the person who pays the premium, regardless of which individual carries the insurance coverage. The deduction is not split between the spouses, even if both are receiving nursing facility services. See Chapter 7 for sources of insurance premium verification.

> **Institutionalized Person Carries and Pays Both Premiums Example:** An institutionalized individual, Mr. Spruce, carries the insurance and pays the premium for himself and his community spouse. The institutionalized spouse receives a deduction for the full premium amount.
>
> **Institutionalized Person Pays Premiums But Does Not Carry Insurance Example:** An institutionalized spouse, Mrs. Geranium, pays the premium for the insurance coverage that her community spouse, Mr. Geranium, carries for them both. The community spouse, Mr. Geranium, is admitted to the nursing facility. The insurance premium continues to be a deduction for Mrs. Geranium since she pays the premium.

➢ *Spenddown*

For all assistance groups (AG), except those with a community spouse, the amount of the client's spenddown, if any, is treated as a non-reimbursable medical expense and subtracted from the client's income along with any other medical expenses the client may have.

➢ *Time Limits and Verification Requirements for Expenses*

▪ *Applicants*

A non-reimbursable medical expense may be permitted only for services provided in the month of application and the three months prior to the month of application. This includes nursing facility expenses incurred during a penalty period for transferring resources and nursing facility expenses incurred during the three months prior period when the client was ineligible for Medicaid due to excessive assets. Only a current payment on, or the unpaid balance of, old bills incurred outside the period of consideration may be permitted as an NRME. See Section 4.14.4.J.3.

EXCEPTION: A deduction may be given if there is evidence of a payment in the three months prior to application, even when the expense was incurred prior to that time.

> **Eligible Ongoing Monthly Payments Example:** Mrs. Carnation applies for Medicaid for payment of nursing home expenses in October. She obtained a wheelchair in June and made payments in July, August, and September. She still owes 10 more payments. The payment may be used as a deduction, even though she purchased it prior to the three-month period, since there is evidence of a payment in the three months prior to application.
>
> **Ineligible Monthly Payments Example:** Same situation as above, except that Mrs. Carnation did not make any payments during July, August, or September. Since she did not incur the expense in the three months prior to the month of application or the month of application and made no payments during the three-month period, no deduction is given.

▪ *Clients Residing in a Nursing Facility*

The request for consideration of a non-reimbursable medical expense must be submitted within one year of the date of service(s).

Documentation must consist of the following:

- An order and statement of the medical necessity from a prescribing physician, dentist, podiatrist or other practitioner with prescribing authority under West Virginia law; and
- An itemization of the services provided. When the request to deduct non-reimbursable medical expenses originates from a nursing facility or is presented by the client as a bill

from a nursing facility, a detailed itemization of the services must be provided. The itemization must include:

- The date of the service or expense;
- The specific medical service;
- The reason no payment was received by the facility; and
- The amount of the expense.

Charges billed to Medicare, Medicaid or private insurance must be accompanied by an Explanation Of Benefits (EOB) to be considered. Only charges denied because they are not covered services may be used.

➢ *Additional Limits for Specific Expenses*

For the items or services listed below, the following limits apply:

- Eye examination and eyeglasses: $300 in a 12-month period
- Eyeglasses: Two pairs in a 12-month period, unless medical necessity is established. The $300 limit in a 12-month period applies.
- Dentures: $3,000 in a 12-month period, unless medical necessity is established
- Hearing Aids: $1,500 in a 12-month period, unless medical necessity is established

Medical necessity is determined by the Worker and/or Supervisor, based upon the documentation provided.

➢ *Expenses which Cannot Be Used*

The following expenses cannot be used as a deduction for non-reimbursable medical expenses:

- Durable Medical Equipment (DME), unless purchased by the client prior to Medicaid payment for nursing facility services, and the cost was not reimbursable from any source;
- Bills for non-payment of the client contribution after Medicaid eligibility for nursing facility services is approved;
- Medical expenses incurred during a period of Medicaid eligibility which are covered by Medicaid;
- Nursing facility expenses incurred during a period of Medicaid ineligibility for excess assets, when the reason for excess assets is non-payment of the client contribution;

- Co-insurance payments while the individual is Medicaid eligible and has Medicare or private health insurance;
- Charges for an ambulance or transportation which is medically necessary for an individual in a nursing facility who is Medicaid and/or Medicare eligible or has private insurance;
- Charges incurred during temporary periods of Medicaid ineligibility when the reason is failure to complete a redetermination and the assistance group (AG) is subsequently reopened with no break in eligibility periods;
- Nursing facility charges when the reason for Medicaid ineligibility is the facility's failure to obtain an approved preadmission screening (PAS); and
- Charges for bed hold days.

24.7.4 FIRST AND LAST MONTH CALCULATIONS

During the first month and last month in which Medicaid participates in the cost of care, the Worker must prorate the client's contribution to his cost of care when he does not spend the full calendar month in the facility. This policy applies only to the first and last months of nursing facility residence when Medicaid participates in the payment. It is not used when the client leaves the facility for other medical treatment, for family visits, etc. During all other months, the client must pay his full contribution and be reimbursed by the facility if an overpayment occurs.

This proration is accomplished as follows:

- Determine the client's total monthly cost contribution amount as for any other nursing facility resident who expects to remain in the facility a full month.
- Divide the client's total monthly cost contribution by the actual number of days in the calendar month. This becomes the client's daily contribution rate, which is used for this purpose only.
- Determine the number of days the client resided or expects to reside in the facility in the calendar month. When the contribution is prorated for the last month of nursing facility residence, only days during which the client resides in the facility are calculated. Days during which the client does not reside in the facility, including bed-hold days, are not considered. Multiply the number of days by the daily contribution rate.
- The result is the client's total cost contribution for the partial month. After all computations have been completed, any cents calculated as part of the result are dropped.

During the first month of Medicaid participation in the cost of care, when the client is not in the facility for a full month, if necessary, the Worker can calculate how much the client retains for his personal needs and how much is contributed to the community spouse and other family members as follows:

- Determine the client's total monthly Personal Needs Allowance (PNA), CSMA, or FMA for a full month.
- Divide the client's monthly PNA, CSMA, or FMA by the actual number of days in the calendar month. This is the client's daily deduction rate which is used for this purpose only.
- Determine the number of days in the calendar month the client expects to reside in the facility and multiply the number of days by the daily deduction then round up.
- The result is the amount of income the client may retain for the PNA, CSMA, or FMA.

24.7.5 FULL MEDICAID AND QMB ELIGIBLE CLIENTS

When a client is eligible for payment for nursing facility services under a full coverage Medicaid group, and is also QMB eligible, he must pay his full monthly contribution, even when Medicare participates in his cost of care, unless Medicare participates for the entire month. When the contribution is prorated for the first or last month of care, it is prorated using the procedure above. The contribution is not prorated based on the date that Medicare begins or ceases participation. When the Worker learns that Medicare participated for an entire month for a QMB eligible client, a DFA-NH-3 must be completed manually by the Worker to change the contribution to $0 for that month.

24.7.6 DETERMINING THE CLIENT'S TOTAL CONTRIBUTION

If the individual is a full Medicaid coverage client or in the Nursing Facility Medicaid coverage group without a spenddown, the resource amount determined in the post eligibility process from above is his total cost contribution.

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

24.7.7 EXAMPLES

Single Individual with OLE, Categorically Needy Example: Mr. Maple, a full coverage Medicaid client, enters a nursing facility and wants Medicaid to pay toward his cost of care. He has $2,500 month unearned income. He is a single individual with OLE.

Medicaid eligibility is already established. Even though his income exceeds 300% of the SSI payment level, he is eligible without a spenddown as a Categorically Needy Medicaid client. Therefore, only post-eligibility calculations must be performed.

Post-eligibility calculations are as follows:

$2,500	Client's gross monthly countable income
-$50	Personal Needs Allowance
$2,450	Remainder
-$175	OLE

$2,275 Client's resource amount which is also his total contribution toward his cost of care.

Single Individual with OLE, Medically Needy Example: Same situation as above except the client is not a full coverage Medicaid client. His Medicaid eligibility must be established as SSI-Related/Monthly Spenddown.

Eligibility calculations are as follows:

$2,500	Income
-$20	SSI Income Disregard
$2,480	Remainder
-$200	MNIL for One Person
$2,280	Monthly Spenddown

The monthly Medicaid cost for his care in the facility is $4,383. Therefore, his spenddown is met for the month and post-eligibility calculations are performed for any additional contribution he must make.

Post-Eligibility calculations are as follows:

$2,500	Income
-$50	Personal Needs Allowance

$2,450	Remainder
-$175	OLE
$2,275	Remainder
-$134	Medicare Part B premium (non-reimbursable medical expense)
$2141	Remainder
-$2,280	Spenddown (non-reimbursable medical expense)
0	Resource Amount

The client has no resource amount, so his total contribution is $2,280, his spenddown amount. The DHHR will not pay any part of the $2,280 because it is the client's spenddown and he is, by definition, liable for it.

Single Individual without OLE, Medically Needy Example: Same as above except the client has no OLE. The client's spenddown amount is the same as determined above.

Post-Eligibility calculations are as follows:

$2,500	Income
-$50	Personal Needs Allowance
$2,450	Remainder
-$134	Medicare Part B premium (non-reimbursable medical expense)
$2,316	Remainder
-$2,280	Spenddown (non-reimbursable medical expense)
$36	Resource Amount

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

$2,280	Spenddown
+$36	Resource Amount
$2,316	Total Contribution

Married Individual without Community Spouse, Medically Needy Example: Mr. Tulip is married, but has been separated from his wife for 10 years. He has one dependent child still living in his home. His monthly income is $2,500. He has non-reimbursable medical expenses of $134.00 (Medicare Part B premium). The monthly Medicaid cost for his care is $4,600. Mr. Tulip is not eligible for the FMA, because there is no community spouse living in his home.

Eligibility calculations are as follows:

$2,500	Income
-$20	SSI Disregard
$2,480	Remainder
-$200	MNIL
$2,280	Monthly Spenddown

Post-Eligibility calculations are as follows:

$2,500	Income
-$50	Personal Needs
$2,450	Remainder
-$134	Medicare Part B premium (non-reimbursable medical)
$2,316	Remainder
-$2,280	Spenddown (non-reimbursable medical)
$36	Resource Amount
+$2,280	Spenddown
$2,316	Total Contribution

Married Individual with Community Spouse, Medically Needy Example: Mr. Holly has the following income:

$1,650	Retirement, Survivors, and Disability Insurance (RSDI)
+$900	Retirement
$2,550	Total Income

He has a community spouse who has $585 per month RSDI income and $365 per month earned income, for a total of $950. His child receives $585 per month RSDI. The monthly Medicaid cost for his care is $5,322.

Eligibility calculations are as follows:

$2,550	Income
-$20	SSI Disregard
$2,530	Remainder
-$200	MNIL
$2,330	Monthly Spenddown

Post-Eligibility calculations for the Community Spouse Deduction and the Family Maintenance Deduction are as follows:

Community Spouse Deduction

$600.00	Shelter
+$421.00	Standard Utility Allowance (SUA)
$1021.00	Total Shelter/Utilities
-$646.50	30% Min. SMS (Community Spouse Housing Allowance)
$374.50	Excess Shelter/Utilities
+$2,155.00	Min. SMS
$2,529.50	
-$950.00	Total gross monthly countable income of Community Spouse
$1,580.00	CSMA (rounded up per CSMA calculation)

Family Maintenance Deduction

$2,155.00	Min. SMS
-$585.00	Income
$1,570.00	Remainder ÷ 3 = $524.00 FMA (rounded up per FMA calculation)
$2,550.00	Income
-$50.00	Personal Needs
$2,500.00	Remainder
-$1,580.00	CSMA
$920.00	Remainder
-$524.00	FMA
396.00	Remainder
-$158.50	Medicare premium and doctor bill
$237.50	Resource and total contribution toward his care

The client has a $237.50 resource to contribute to his care. Because there is a community spouse, the spenddown amount determined in the eligibility process is not subtracted as a non-reimbursable medical expense and is not added to the resource to determine his total contribution.

24.7.8 SPLIT MONTHS

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

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

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

Step 3: Compare Step 1 to Step 2.

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

If Step 1 is greater than Step 2, the Step 2 amount is paid to the first facility and the difference between Step 1 and Step 2 is paid to the second facility.

24.7.9 NOTIFICATION AND CALCULATION SHEETS RELATED TO COST OF CARE

All notification letters regarding the client’s contribution to his cost of care must contain the following statement:

> “This resource must be paid for in-facility days and bed-hold days unless you are notified otherwise in writing.”

24.7.9.A Notice of Client’s Contribution toward His Cost of Care (DFA-NH-3)

The DFA-NH-3 is primarily used to notify the client or his authorized representative, the nursing facility administrator and the LTC Unit of the client's contribution to his cost of care. The DFA-NH-3 is not a substitute for any client notification letter. When appropriate, the DFA-NH-3 is attached to letters notifying the client about a change in benefits or a decision on an application. The IM-NL-LTC-1 calculation form should also be attached. When there is a related change in the CSMA and/or the FMA, the IM-NL-LTC-2 calculation form should also be attached.

The form is prepared when there is any change in the client's contribution toward his cost of care. The form is completed when the eligible client first enters the nursing facility, leaves a nursing facility, is transferred to a different nursing facility, or when the ineligible individual who is in a nursing facility becomes eligible for payment. When the client resides in more than one nursing facility in the same month and his contribution must be divided, see Section 24.7.8.

This form is also used to notify the Bureau for Medical Services (BMS) LTC unit that it is to pay for LTC Services for individuals who have requested a waiver of their denial of LTC services based on the Undue Hardship Provision. These clients may be eligible for up to 30 days of payment for bed-hold days while awaiting a decision of the Undue Hardship Committee. When a DFA-NH-3 is sent to the LTC Unit indicating availability of payment for this reason, the payment is not processed automatically. Payment for bed-hold days while awaiting a decision is not made for individuals denied due to excessive home equity.

24.7.9.B LTC Post-Eligibility Calculations (IM-NL-LTC-1)

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

24.7.9.C Determination of Community Spouse and Family Maintenance Allowance for LTC programs (IM-NL-LTC-2)

The IM-NL-LTC-2 is a calculation sheet used to determine the CSMA and FMA for nursing facility cases. It must be sent to the client or his authorized representative with the appropriate notice of decision form and DFA-NH-3 for notification when there is a change in the CSMA or the FMA.

24.8 ASSETS

Applicants for nursing facility services must meet the asset test for their eligibility coverage groups, except for Modified Adjusted Gross Income (MAGI) groups. The asset level for those eligible in the Nursing Facility coverage group and Supplemental Security Income (SSI)-Related/Monthly Spenddown is the same as SSI-Related Medicaid When both spouses are institutionalized and both apply for nursing facility services, the SSI-Related Medicaid asset limit for a couple is used to determine eligibility. See Chapter 5 for the asset limit of the appropriate coverage group.

24.8.1 ASSET ASSESSMENTS

When an institutionalized person has a spouse in the community, once the Worker determines the value of the assets as governed by Chapter 5, he completes an Asset Assessment, described below. The purpose of the Asset Assessment is to allow the spouse of an institutionalized individual to retain a reasonable portion of the couple's assets and to prevent the impoverishment of the community spouse.

This section is not applicable to clients eligible for or enrolled in MAGI eligibility groups or couples where both spouses are institutionalized.

24.8.1.A When to Conduct an Asset Assessment

When determining eligibility for nursing facility services for an individual who has a community spouse, the Worker must complete a one-time assessment of the couple's combined countable assets, called an Asset Assessment.

A legally married individual and his spouse, although separated, are treated as a couple for the Asset Assessment, regardless of the length of the separation.

An Asset Assessment is completed when an institutionalized individual transfers to a nursing facility in West Virginia, even if one was previously completed in the former state of residence.

An asset assessment must be completed as of the first continuous period of institutionalization. The first continuous period of institutionalization is the date the client first enters the nursing facility and remains for at least 30 days or is reasonably expected to remain for 30 days at the time the individual enters the facility. The spousal limits in effect at the time the assessment is

completed are used. If requested by the client or authorized representative, the assessment may be completed prior to application as of the first continuous period of institutionalization.

Nursing facilities are required to advise all new admissions and their families that an Asset Assessment is available upon request from the local office. The agency has developed a statement concerning the availability of Asset Assessments. Nursing facilities provide this "Patient's Bill of Rights" as part of their admission package. See Appendix B.

When a Medicaid client in a MAGI coverage group applies for payment of nursing facility services, an Asset Assessment is not required. However, if a MAGI client is later determined eligible in a non-MAGI group, an Asset Assessment is completed with information using the date the client first entered the nursing facility.

The assessment is completed on form IM-NL-AC-1 or in the eligibility system.

When requested, the Worker must advise the individual(s) of the documentation required for the assessment. Verification of ownership and the fair market value (FMV) (see Section 24.8.2.A.1 for definition) must be provided. When it is not provided, the assessment is not completed.

The Worker documents the total value of all countable assets.

The following forms are used as part of the asset assessment:

- Notice of Decision – Asset Assessment (ES-NL-D, also known as the DFA-NL-D)

  This form is used when the client requests an Asset Assessment but has not formally applied for Medicaid. The ES-NL-D is used to notify the client that the results of an asset assessment cannot be appealed unless an application for nursing facility care is made. See Section 24.8.1.C. Form IM-NL-AC-1 must be mailed with the ES-NL-D. When the Asset Assessment is completed in the eligibility system, alternate notification is sent.

- Assets Computation and Asset Assessment (IM-NL-AC-1)

  This form is used to complete an Asset Assessment. The Asset Assessment may be completed in the eligibility system.

24.8.1.B Calculation of the Community Spouse's Share

The spouse's share is computed as follows:

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

Step 2: Compare the amount from Step 1 to $25,728, the Community Spouse Asset limit. If the Step 1 amount is equal to or less than $25,728, all assets are attributed to the community spouse. If not, go to Step 3.

Step 3: Divide the Step 1 amount by 2 and compare to $25,728. If one-half of the Step 1 amount is equal to or less than $25,728, the community spouse is attributed $25,728 and the remainder belongs to the institutionalized spouse. If not, go to Step 4.

Step 4: When one-half of the Step 1 amount is greater than $25,728, one-half of the total assets (Step 1 amount) is attributed to the community spouse, not to exceed $128,640, the maximum community spouse asset limit.

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

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

24.8.1.C Notification Requirements

When the assessment is complete, the Worker must provide each member of the couple with a copy of the eligibility system asset assessment or the Assets Computation and Asset Assessment (IM-NL-AC-1). A copy of the IM-NL-AC-1 is retained in the case record.

The Worker must also notify the community spouse using the Notice of Decision – Asset Assessment form (ES-NL-D) or the appropriate eligibility system form that although the assessment may be made prior to application, it may not be appealed until a Medicaid application is made.

24.8.1.D Revisions to the Asset Assessment

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

24.8.1.E Additional Asset Exclusions for Institutionalized Spouses

The institutionalized individual is eligible for Medicaid regardless of having assets over the allowable limit, if he is legally prevented from transferring the assets, which would otherwise make him ineligible, to the community spouse.

Certain asset-related denials of long term care (LTC) Services are subject to waiver due to the Undue Hardship Provision.

Certain individuals who meet the gross income test but are ineligible for Medicaid due to being over the allowable asset limit, may be eligible for the LTCIP Asset Disregard.

24.8.1.F Transfers of Assets to the Community Spouse

Once initial eligibility has been established, assets that were not counted for the institutionalized spouse must be legally transferred to the community spouse.

Assets cannot merely be attributed to the community spouse, but must actually be transferred to the community spouse if they are to be excluded in determining continuing Medicaid eligibility of the institutionalized spouse. Assets legally transferred to the community spouse based on the Asset Assessment are allowable transfers of resources.

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

Once Medicaid eligibility is established, the assets of the community spouse based on the Asset Assessment are not counted for the institutionalized spouse. In addition, when assets such as the home and attributed assets legally transferred to the community spouse are subsequently transferred by the community spouse, no penalty is applied to the institutionalized spouse.

24.8.1.G Additional Asset(s) Received/Obtained

When the institutionalized spouse obtains an additional asset(s) after the community spouse’s share has been calculated and initial Medicaid eligibility is established, the additional asset(s) is excluded when one of the following conditions exist:

- The new asset(s), combined with the other assets the institutionalized spouse intends to retain, does not exceed the asset limit for one person; and/or
- The institutionalized spouse intends to transfer the new asset(s) to the community spouse who has assets below the previously determined spousal amount. To exclude the additional asset(s), the institutionalized spouse or his authorized representative must promptly report receipt of the new asset(s) and provide the Worker with a written statement that he intends to transfer the new asset(s) to the community spouse within 90 days.
- The Qualified Long Term Care Insurance Partnership (LTCIP) Policy has paid benefits to or on behalf of the institutionalized spouse that equal or exceed the amount of the newly acquired countable asset.

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

24.8.2 TRANSFER OF RESOURCES

Under the transfer of resources policy, the Worker must deny coverage of LTC Medicaid services to otherwise eligible institutionalized individuals who transfer (or whose spouses transfer) resources for less than fair market value (FMV).

The current asset and income transfer policy governs transfers made after February 8, 2006 and applies to payments made for institutional care on or after March 1, 2009.

This section outlines which transfers of resources are allowable (or permissible) and which result in a penalty that delays the applicant's eligibility for Medicaid coverage of LTC services. Whether the transfer is considered permissible depends on the timing of the transfer, whether the client was compensated, for whose benefit the transfer was made and other factors.

24.8.2.A Definitions

For purposes of Transferring Resources, the following definitions apply.

24.8.2.A.1 Fair Market Value (FMV)

The FMV is an estimate of the value of a resource, if sold at the prevailing price at the time it was actually transferred.

For a resource to be considered transferred for FMV, or to be considered transferred for valuable consideration, the compensation received for the resource must be in a tangible form, with intrinsic value. A transfer for love and consideration, for example, is not considered a transfer for FMV. Also, while relatives and friends legitimately can be paid for care they provide to the individual, it is presumed that services provided for free, at the time, were intended to be provided without compensation. Therefore, a transfer to a relative for care provided in the past normally is not a transfer of assets for FMV. However, an individual may rebut this presumption. See Transfers to Pay for Personal Care Services in Section 24.8.2.F.

24.8.2.A.2 For the Sole Benefit of

For a transfer or trust to be considered for the sole benefit of a spouse, disabled child, or a disabled individual under age 65, the transfer or trust cannot benefit any other in any way, either at the time of the action, or at any time in the future, except as provided below. The agreement must be in writing.

EXCEPTION: A trust may provide for reasonable compensation for a trustee to manage the trust, as well as for reasonable costs associated with investing or otherwise managing the funds or property in the trust. In defining reasonable compensation, consider the amount of time and effort involved in managing a trust of the size involved, as well as the prevailing rate of compensation, if any, for managing a trust of similar size and complexity.

If a beneficiary is named to receive the funds remaining in a trust upon the individual's death, the transfer is considered made for the sole benefit of the individual if the Department of Health and Human Resources (DHHR) is named as the primary beneficiary for up to the amount paid for services to the individual. The designated beneficiary receives any remaining amount.

24.8.2.A.3 Institutionalized Individual

An institutionalized individual is:

- An individual who is an inpatient in a nursing facility, or who is an inpatient in a medical institution, and for whom payment is made for a level of care provided in a nursing facility; or,
- An individual who is a Home and Community Based Services (HCBS) waiver participant.

For purposes of this section, a medical institution includes intermediate care facilities for individuals with intellectual disabilities (ICF/IID).

24.8.2.A.4 Resources

Resources include all income and assets of the individual and of his spouse that are counted for SSI-Related Medicaid purposes.

This includes some income or assets which the individual or the spouse is entitled to, but does not receive, because of any action or inaction by:

- The individual or his spouse;
- A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or
- Any person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

Resources to which an individual or spouse is entitled include resources to which the individual is actually entitled, or would be entitled if action had not been taken to avoid receiving the resources.

Examples of actions which cause income or assets not to be received are:

- Irrevocably waiving pension income;
- Waiving an inheritance;
- Not accepting or accessing injury settlements;
- Settlements which are diverted by the defendant into a trust or similar device to be held for the benefit of the plaintiff; or

- Refusal to take legal action to obtain a court-ordered payment that is not being paid, such as child support or alimony.

24.8.2.A.5 Valuable Consideration

Valuable consideration means that an individual receives in exchange for his or her right or interest in a resource some act, object, service, or other benefit which has a tangible and/or intrinsic value to the individual that is roughly equivalent to or greater than the value of the transferred resource.

24.8.2.A.6 Uncompensated Value

The uncompensated value is the difference between the FMV at the time of transfer (less any outstanding loans, mortgages, or other encumbrances on the resource) and the amount received for the resource.

24.8.2.A.7 Look-Back Period

The look-back period is the length of time for which the Worker looks back for any resource transfers. The look-back period is 60 months, whether or not a trust fund was involved. The look-back time period begins the month the client is both institutionalized and has applied for Medicaid.

See Chapter 5 for further information about funds in revocable or irrevocable trusts.

24.8.2.B Permissible Transfers

The following types of transfers do not result in a penalty for transferring resources.

24.8.2.B.1 Transfer of the Home

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

- To the client's spouse.
- To the client's minor child (under age 21).
- To the client's disabled child regardless of age. The Social Security Administration (SSA) definition of disability is used. Therefore, any person medically approved for or receiving disability-based Retirement, Survivors, and Disability Insurance (RSDI) and/or disability-based SSI meets the definition, as well as persons who are determined disabled by the medical review team (MRT). If no disability determination has been made, the case must be submitted for a MRT decision.
- To the client's sibling who has an equity interest in the home and who resided in the home for at least one year immediately prior to the client's institutionalization.
- To the client's child(ren) who was residing in the home for at least two years immediately prior to the client's institutionalization and who provided care to the individual which allowed him to remain at home rather than being institutionalized.

24.8.2.B.2 Transfers for the Benefit of the Spouse or Disabled Child

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

- To the client's spouse or to another person for the sole benefit of the client's spouse not to exceed the amount determined attributable to the community spouse during the Asset Assessment.
- From the client's spouse to another person for the sole benefit of the client's spouse not to exceed the amount determined attributable to the community spouse during the Asset Assessment.
- To the client's disabled child regardless of age. The Social Security Administration (SSA) definition of disability is used. Therefore, any person medically approved for or receiving disability-based Retirement, Survivors, and Disability Insurance (RSDI) and/or disability-based SSI meets the definition, as well as persons who are determined disabled by the medical review team (MRT). If no disability determination has been made, the case must be submitted for a MRT decision.

All transfers to another person for the sole benefit of the client’s spouse or to the client’s disabled child must be accomplished by a written instrument of transfer, such as a trust, which legally binds the parties to a specific course of action and specifies the conditions under which the transfer was made, and names those who benefit from the transfer.

24.8.2.B.3 Transfer to a Trust

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

This section applies to any trust established on or after August 11, 1993. For trusts prior to August 11, 1993, see Chapter 5, Appendix B.

Generally, all trusts are counted as assets, regardless of their purpose, restrictions on distributions or on the trustee's discretion to distribute the funds, whether acted on or not. There are exceptions to this general rule, and trusts established by a will are treated differently from those not established by a will. In addition, sometimes revocable and irrevocable trusts are treated differently. Details are found below.

If a trust is made up of the client's resources and those of one or more other persons, only the amount established with the client's resources is counted.

For purposes of this item, the terms "individual" or "client" include:

- The client;
- His spouse;
- Any person, including a court or administrative body, with legal authority to act in place of, or on behalf of, the individual or the individual's spouse; and,
- Any person, including a court or administrative body, acting at the direction of, or upon the request of, the individual or the individual's spouse.

➢ *Trusts Established by Will*

A trust is treated as an asset only to the extent that it is available to the client. Clauses included in a trust that limit the trustee's use of the funds (e.g., exculpatory clauses) are recognized and the amount of funds affected by such exculpatory clauses is excluded.

Irrevocable trusts are excluded, regardless of the amount. There is no penalty for the placement of funds in an irrevocable trust.

➢ *Trusts Not Established by Will*

When the following two conditions are met, the trust policy contained below in this item is applied. If the two conditions are not met, the fund is treated as any other bank account.

1. An individual has established a trust when his resources were used to form all or part of the corpus of the trust.
2. Any of the following persons established the trust for the individual by any vehicle other than by will:
    - Individual;
    - Individual's spouse;
    - A person, including a court or administrative body, with legal authority to act in place of, or on behalf of, the individual or the individual's spouse; or
    - A person, including any court or administrative body, acting at the direction of, or upon the request, of the individual or the individual's spouse.

➢ *Excluded Trusts*

In the following four trust situations, the trust is totally excluded. In addition, establishment of these trusts is not treated as an uncompensated transfer of resources.

NOTE: For these purposes, the SSA definition of disability is used. Therefore, any person medically approved for or receiving SSI, based on disability, meets the definition, as well as persons who have been determined disabled by the MRT. If no disability determination has been made, the case must be submitted for a MRT decision. See Section 13.8.

1. A trust containing the assets of an individual, under age 65, who is disabled, and which is established for his benefit by a parent, grandparent, legal guardian, or a court. The individual may establish the trust for himself on or after December 13, 2016. The exception continues even after the individual becomes age 65, as long as he continues to be disabled. This is commonly known as a special needs trust.

   To qualify for the exception, a trust must contain a provision that the State will receive all amounts remaining in the trust upon the death of the individual, up to the total Medicaid payments made on his behalf.
2. A trust which contains the assets of an individual who is disabled and which meets all of the following conditions:
    - The trust is established and managed by a non-profit association;
    - A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools the funds in these accounts;

- Accounts in the trusts are established solely for the benefit of the disabled individual;
- Accounts in the trusts are established by the individual, his parent, grandparent, legal guardian or by a court; and,
- The trust must include a specific provision that amounts remaining in the individual's account that are not retained by the trust upon the client's death, must be used to reimburse the State for Medicaid and/or WV WORKS payments which were made on the individual's behalf.

NOTE: When an individual is approved for Medicaid and has an excluded trust described above, for which Medicaid must be the beneficiary, the Worker must fax a copy of the trust document and the Medicaid client's name, case number and name of the client's power-of-attorney or authorized representative, if applicable, to the current contract agency for Estate Recovery. Information about this agency is in Appendix E.

3. Burial trusts which meet all the following conditions:
    - The individual signs a contract with the funeral director promising prepayment in return for specific funeral merchandise and services;
    - The contract is irrevocable;
    - The individual pays the agreed-upon amount to the funeral director in the form of a direct cash payment, purchase or transfer of a life insurance policy or annuity which is assigned to the funeral director; and,
    - The funeral director, in turn, places the pre-need payment or device into a trust or escrow account which the funeral director establishes himself. If the client establishes the trust or other device himself, the amount may be considered a transfer of resources.
4. A trust established with a settlement or funds received from the following:
    - Factor VIII or IX Concentrate Blood Products Litigation, MDL 986, No. 93-C-7452, ND of Illinois
    - Ricky Ray Hemophilia Relief Fund
    - Walker v. Bayer Settlement which compensates hemophiliacs who contracted the Human Immunodeficiency Virus (HIV) from contaminated blood products

➢ *Revocable Trusts*

Once the Worker determines the trust was not established by a will and does not meet one of the exceptions above, the following rules apply:

- The corpus of the trust is considered an available asset.
- Payments from the trust to the client or for his benefit are counted as income.

➢ *Irrevocable Trusts*

Once the Worker determines the trust was not established by a will and does not meet one of the exceptions above, the following rules apply:

- If there are any circumstances under which payments from the trust could be made to the client or for his benefit, that portion of the corpus, or the interest, is an asset.
- If payments are made from the available corpus, or interest, to the client or for his benefit, the amount is treated as income.

▪ *Payment for the Client's Benefit*

Throughout this item "payments made on behalf of the client" or "for his benefit" means payments of any kind to another entity, such that the client derives some benefit from the payment. This may include, but is not limited to, clothing, television, payments for services or care rendered, whether medical or personal, payments to maintain a home, etc. Any payment for the benefit of the client is counted, even if it is not customarily counted in determining Medicaid.

In determining whether payments can or cannot be made from a trust, the Worker must take into account any restrictions on payments, such as use restrictions, exculpatory clauses, and limits on trustee discretion, which may be included in the trust.

> **Client Benefit Example:** If a trust provides that the trustee can disburse only $1,000 out of a $20,000 trust, only the $1,000 is treated as a payment that could be made to the client or for his benefit. The remaining $19,000 is treated as an amount which cannot, under any circumstances, be paid to, or for the benefit of the client.
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> **Restricted Use Example:** A trust contains $50,000 which the trustee can disburse only in the event the grantor needs a heart transplant. The full amount is payment which could be made under some circumstances, even though the likelihood of payment is remote if the client does not have heart problems.

In determining whether payments can or cannot be made from a trust, the Worker must take into account restrictions included in the trust on how payments can be made; the Worker must not take into account when payments can be made. When a trust provides, in some manner, that a payment can be made, even though that payment may be sometime in the future, the trust must be treated as providing that payment can be made from the trust.

➢ *Undue Hardship*

There is a hardship provision for LTC Medicaid which allows DHHR to exclude a trust when counting it results in undue hardship for the client. All decisions about undue hardship are made by the Undue Hardship Waiver Committee. Any requests for such a determination are submitted in writing and must show complete details about the undue hardship which will result. See "Undue Hardship" in Section 5.1 and Section 24.8.2.B.7 below.

24.8.2.B.4 Transferred Resources Returned

When the client reports assets transferred for less than FMV have been returned to the client, the Worker must verify this information. Any return of assets must be to the client rather than to another individual on his behalf or paid directly to the long term care facility.

When the transferred assets have been returned to the client in full, no penalty is applied. If a penalty has already been applied, a retroactive adjustment to the beginning of the penalty period is required.

However, the client must always be asset eligible as of the first day of the month for any months the transfer penalty period is adjusted. When all transferred assets have been returned in full, the returned assets must be counted in determining eligibility for LTC services during the retroactive period and ongoing, unless the asset would have otherwise been considered exempt. Advance notice is required before closing other ongoing Medicaid coverage. The client's contribution to cost of care must also be determined.

For new applications or new transfers reported after August 1, 2018, if the transferred assets are returned only in part, adjustments to the applied penalty period are not allowed. The applied penalty period continues uninterrupted for the full duration originally calculated. The returned assets are, however, considered in determining eligibility for all other Medicaid coverage groups during the transfer penalty. Advance notice is required before closing other ongoing Medicaid coverage.

> **Return of Transferred Funds Example:** Ms. Daisy transferred all the money from her savings account to her son in February. The Worker calculates the

transfer penalty period to be nine months, running March through November. In June, Ms. Daisy's son returns all the transferred assets. After appropriately verifying the returned assets, the transfer penalty is removed. However, the returned funds must be counted in determining eligibility retroactively back to March. These funds put Ms. Daisy over the asset limit from March through June, when they were returned. In June, Ms. Daisy uses the returned money to pay her nursing home bill for services received in March through June. Ms. Daisy is now under the asset limit and is otherwise eligible as of July 1. She is eligible for LTC services as of July 1. The Worker must ensure Ms. Daisy receives the LTC benefit beginning July 1. Ms. Daisy's contribution to cost of care must also be determined.

Partial Return of Transferred Funds Example: Mr. Elm transferred $60,000 from his savings account to his son in February. The Worker calculates the transfer penalty period to be nine months, running March through November. In June, Mr. Elm's son returns only $30,000 of the transferred money. Since only part of the assets were returned, no adjustment to the penalty period is allowed. The partially returned funds are considered an available asset for Mr. Elm during the penalty period, and after advance notice, Mr. Elm's coverage under other Medicaid groups is closed due to excess assets. However, since the transfer penalty has already started, the penalty continues to run from March through November.

Multiple Transfers with Partial Return Example: During the lookback period, Ms. Poppy transferred $20,000 from her savings account, a vehicle, a certificate of deposit, and some stocks to her daughter. The Worker calculates the penalty period by adding all the transfers together. The total transfer penalty period is nine full months, running January through September. In May, Ms. Poppy's daughter returns the entire $20,000 she received from the savings account, but she does not return any other assets. Even though Ms. Poppy's daughter returned one full asset, she did not return the full amount of assets used to calculate the applied transfer penalty. Therefore, no adjustment to the penalty is allowed. The partially returned funds are considered an available asset for Ms. Poppy during the penalty period, and after advance notice, Ms. Poppy's coverage under other Medicaid groups is closed due to excess assets. However, since the transfer penalty has already started, the penalty continues to run from January through September.

24.8.2.B.5 Client Intended Fair Market Return or Other Valuable Consideration

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

24.8.2.B.6 Transfer Was Not to Qualify for Medicaid

When a transfer of resources was exclusively for a purpose other than to qualify for Medicaid, no penalty is applied.

NOTE: A transfer is assumed to be for the purpose of qualifying for LTC services. The burden is on the individual to prove otherwise. The Worker and Supervisor can make this decision.

> **Transfer Intent Example 1:** Mrs. Rhododendron has a stroke and enters the nursing facility on October 15, 2016. Her daughter's home was in foreclosure and the mother transferred $5,000 to her on September 19, 2016 to prevent foreclosure. The Worker verifies the situation with the foreclosure notice dated September 4, 2016 and the mother's withdrawal and check to the daughter on September 19, 2016 for the exact amount of the foreclosure of $5,000. The Worker and Supervisor determine Mrs. Rhododendron did not transfer money to qualify for Medicaid.
>
> **Transfer Intent Example 2:** Mr. Geranium, a widowed man, has failing health and transfers $25,000 to each of his children before he enters the nursing facility. The children are not disabled. The transfer is assumed to be for the purpose of qualifying for Medicaid.

24.8.2.B.7 Denial Would Result in Undue Hardship

When the Worker determines the individual is otherwise eligible for LTC services, an undue hardship may exist when a denial of payment for LTC services is due to one or more of the following asset policies:

- Excessive home equity;
- Transfer to a non-permissible trust; and/or,
- A transfer of asset penalty.

For undue hardship to exist, the denial must result in:

- Depriving the individual of medical care to the extent that the individual's health or life would be endangered; or
- Depriving him of the ability to obtain food, clothing, shelter or other necessities of life.

➢ *Notice of Right to Request an Undue Hardship Waiver (DFA-NL-UH-1) and the Fair Hearing Request Form (DFA-FH-1)*

When the Worker determines the individual is otherwise eligible for LTC services except for one or more of the asset policies listed above to which an undue hardship provision applies, he gives the individual the Notice of Right to Request an Undue Hardship Waiver (DFA-NL-UH-1) and the Fair Hearing Request form (DFA-FH-1) at the time of the eligibility decision, which provides him the opportunity to request a waiver of the denial due to undue hardship. The individual, his authorized representative or a nursing facility staff member with the client's permission, can use these forms to apply for an undue hardship waiver.

➢ *Application for an Undue Hardship Waiver (DFA-UH-5)*

The Application for an Undue Hardship Waiver (DFA-UH-5) must be attached to the DFA-NL-UH-1. The DFA-UH-5 is the application for the waiver. It must be completed and returned to the Worker within 13 days of notice of the eligibility decision. Upon receipt, the Worker immediately mails, emails, or faxes it to the Bureau for Medical Services (BMS) Policy Unit for distribution to the Undue Hardship Waiver Committee.

The DFA-UH-5 must include a signature of the individual for whom the waiver is filed when the LTC facility is completing the request. It must include an explanation of any efforts made to resolve the asset issue that resulted in the LTC services denial. Documentation that supports these attempts must be attached. Details regarding the individual's undue hardship must be explained. If the DFA-UH-5 is not returned complete and timely, no additional notice occurs and the negative eligibility decision and any penalty applied remains.

An individual who resides in a facility and requests an Undue Hardship Waiver is eligible for payment of up to 30 bed-hold days from the date the DFA-UH-5 is received by the BMS Policy Unit until a decision is made by the Committee. The Committee has 60 days to make a decision concerning the Waiver request. Denial of payment of LTC services due to excessive home equity is not subject to payment of bed-hold days.

➢ *Decision for Request of Undue Hardship Waiver Form (DFA-NL-UH-2)*

If the waiver request is not appropriate for the Committee, it is returned to the local office which made the eligibility decision. The individual is notified of the Committee's decision via the

Decision for Request of Undue Hardship Waiver form (DFA-NL-UH-2). The Committee forwards the DFA-NL-UH-2 to the individual, with a copy to the Supervisor and Worker.

The decision of the Committee to deny the request can be overturned by a State Hearings Officer, therefore a DFA-FH-1 is sent. The local office must notify the BMS Policy Unit when a hearing request regarding the Committee's decision is received, and also advise the Regional Attorney. A member of the Committee will be available, via telephone, to participate in a Fair Hearing regarding the denial of the DFA-UH-5, but not to discuss the ineligibility for LTC services for reasons other than those related to excessive home equity, trust, and/or transfer issues.

24.8.2.B.8 Transfer of Resources Previously Disregarded by LTCIP Asset Disregard

If an individual in the Nursing Facility coverage group with income less than 300% of the SSI payment for one person transfers an asset that was previously disregarded by the LTCIP Asset Disregard, the transfer is not subject to a transfer penalty since the asset was previously disregarded.

If the individual obtains an additional countable asset that causes him to exceed the allowable asset amount, he must verify additional payments made to him or on his behalf by the LTCIP Policy in addition to the amount of payments that were previously used to disregard the assets that were transferred.

The amount of the individual's estate that was protected from Estate Recovery is reduced by the same amount as the value of the asset that was transferred.

> **LTCIP Example:** Mr. Sunflower is in a nursing facility and applies for Medicaid on November 1, 2016. Mr. Sunflower's income is less than 300% of the SSI payment for one person but he has $12,000 in individual assets consisting of $5,000 in an accessible money market and $5,000 in stocks. He verifies ownership of a $100,000 Qualified LTICP Policy issued after July 1, 2010, the date West Virginia implemented the LTCIP. He can also show insurance payments for a previous nursing facility stay in the amount of $10,000 to the nursing facility after July 1, 2010. The Worker disregards his money market and stocks and Medicaid eligibility is effective November 1, 2016.
>
> At redetermination, Mrs. Sunflower reports transferring the stock to their son. The transfer is not subject to a penalty since the asset was previously disregarded. However, since insurance payments verified as paid by the LTCIP Policy on behalf of Mr. Sunflower were applied to disregard the value of the stock, and resulted in Mr. Sunflower being eligible for and receiving Medicaid, these same

insurance payments cannot be used again to disregard other assets. Should Mr. Sunflower's money market increase in value or if he acquires additional countable assets, he must verify additional payments by the insurance company before any other assets can be disregarded.

Mr. Sunflower's amount of assets that were protected at estate recovery is also reduced from $10,000 to $5,000 since the previously disregarded stock was transferred to his son.

24.8.2.B.9 Transfer on Death Deed

A client who transfers his property to a death beneficiary, while retaining the right to ownership, may execute a deed known as a transfer on death deed. This allows the owner to retain all rights of ownership, including the right to revoke the deed or transfer or encumber the property. At the owner's death, the property passes directly to the death beneficiary without going through probate. The deed must be recorded at the courthouse during the owner's lifetime to be valid. A transfer on death deed is not subject to a transfer penalty as the client still retains ownership in the property until their death.

West Virginia may file a Medicaid lien against the property of the Medicaid client during the client's lifetime. If the Medicaid lien still exists at the time of the Medicaid client's death, the lien would remain imposed against the property transferred to the death beneficiary of the transfer on death deed, under West Virginia law.

24.8.2.C Transfers That Are Not Permissible

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

24.8.2.D Transfers Related to a Life Estate

24.8.2.D.1 Transfer of Property with Retention of a Life Estate

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

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

Step 1: To determine the value of the transferred property, subtract any loans, mortgages or other encumbrances from the fair market value (FMV) of the transferred property.

Step 2: Determine the age of the life estate holder as of his last birthday and the life estate factor for that age found in Chapter 5, Appendix A. Multiply the FMV of the transferred property by the life estate factor. This is the value of the life estate.

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

Step 4: Divide the Step 3 amount by the State's average monthly nursing facility private pay rate of $9,930. The result is the length of the penalty.

NOTE: The value of a life estate may be excluded as a homestead property, if the individual intends to return to it.

24.8.2.D.2 Transfer of a Life Estate

The value of a life estate interest is considered a transfer of resources when it is transferred or given as a gift.

24.8.2.D.3 Purchase of a Life Estate

The purchase of a life estate interest in another individual's home is treated as an uncompensated transfer, unless the individual who purchased the life estate interest resides in the home for at least one year after the purchase. The amount of the transfer is the entire amount used to purchase the life estate.

If the individual has resided in the home for at least one year after the life estate was purchased, determine the value of the life estate as follows.

➢ *No Intent to Return*

If the individual does not intend to return to the home in which the life estate was purchased, the value of the life estate is an asset, see Section 5.5.

When the individual has no intent to return due to domestic abuse, the life estate continues to be excluded until the individual establishes a new principal place of residence or otherwise takes action rendering the life estate no longer excludable.

➢ *Intent to Return*

The purchase of a life estate may be excluded as homestead property if the individual intends to return to the home and the individual resided in the home for at least one year after the purchase.

24.8.2.E Transfer to Purchase an Annuity

An annuity that is revocable or assignable is considered to be a countable asset. See Section 5.5.2 for more information on treating annuities as an asset.

24.8.2.E.1 Annuity-Related Transfers

NOTE: When an individual is approved for LTC Medicaid and has an excluded annuity described below, for which Medicaid must be the beneficiary, the Worker must securely forward a copy of the trust document and the Medicaid recipient's name, case number, and name of the recipient's Power of Attorney or legal representative, if applicable, to the current contract agency for Estate Recovery. Information about this agency is in Chapter 24, Appendix E.

➢ *Institutional Spouse is Annuitant*

An annuitant is defined as a person who receives an annuity.

Establishment of an annuity is treated as a transfer of resources, unless the annuity meets the following criteria:

- The individual disclosed to the State any interest the individual or his spouse has in any annuity;
- The State is named as the remainder beneficiary, or as the second remainder beneficiary after a community spouse or minor or disabled adult child, for an amount at least equal to the amount of Medicaid benefits provided when the annuity is purchased by an applicant/client or spouse;
- The annuity was purchased by or on behalf of the individual and one of the three following situations applies:

    1. The annuity is considered either:
        - An individual retirement annuity (according to Section 408 (b) of the Internal Revenue Code of 1986 (IRC); or
        - A deemed Individual Retirement Account (IRA) under a qualified employer plan (according to Section 408§ of the IRC).

        OR

    2. The annuity is purchased with proceeds from one of the following:
        - A traditional IRA [IRC Section 408 § (a)]; or
        - Certain account or trusts which are treated as traditional IRAs [IRC Section 408§(c)]; or
        - A simplified retirement account [IRC Section 408 § (p)]; or
        - A simplified employee pension [IRC Section 408 § (k)]; or
        - A Roth Individual Retirement Account (IRA) (IRC Section 408A).

        OR

    3. The annuity meets all of the following requirements:
        - The annuity is irrevocable and non-assignable; and
        - The annuity is actuarially sound; and
        - The annuity provides payments in approximately equal amounts, with no deferred or balloon payments. Endowment Life Insurance Policies are considered balloon annuities and subject to a transfer penalty.

➢ *Community Spouse Is Annuitant*

Establishment of an annuity is treated as a transfer of resources, unless the annuity meets the following criteria:

- The individual disclosed to the State any interest the individual or his spouse has in any annuity; and,
- The State is named as the remainder beneficiary, or as the second remainder beneficiary after a community spouse or minor or disabled adult child, for an amount at least equal to the amount of Medicaid benefits provided when the annuity is purchased by an applicant or spouse.

If the annuity does not meet all stated requirements above, the full purchase value is considered the amount of the transfer.

24.8.2.E.2 Actuarial Soundness

In order for an annuity to be actuarially sound, the average number of years of expected life remaining for the individual who benefits from the annuity must coincide with the life of the annuity. If the individual is not reasonably expected to live longer than the guarantee period of the annuity, the individual will not receive FMV. The annuity is not, then, actuarially sound and a transfer of resources for less than FMV has taken place.

Periodic life tables can be found in the appendices as follows:

- For annuities purchased prior to February 8, 2006, use the Periodic Life Tables found in Appendix C. The penalty is considered to have occurred at the time the annuity was purchased prior to February 8, 2006. Only the amount that is not actuarially sound is treated as an uncompensated transfer.
- For annuities purchased on or after February 8, 2006, use the Period Life Tables in Appendix D of this chapter.

NOTE: The Deficit Reduction Act of 2005 (DRA) was signed into law on February 8, 2006. The DRA made significant changes to the policies for long term care asset transfers.

Meets Criteria Example: A 65-year-old man purchases a $10,000 irrevocable, non-assignable annuity on July 28, 2008 which is to be paid over 10 years in equal payment amounts, and names the State of West Virginia as the second remainder beneficiary after his disabled son. His life expectancy, according to Appendix D, is 16.05 years. The annuity is irrevocable, non-assignable, actuarially sound, provides equal payment amounts and the state is named as a secondary remainder beneficiary. No transfer of resources has taken place.

Life Expectancy Example: An 80-year-old man purchases a $10,000 annuity on January 1, 2006 to be paid over 10 years. According to Appendix C, his life expectancy is only 6.98 years. Therefore, the amount which will be paid out by

the annuity for 3.02 years is considered an uncompensated transfer of resources that occurred at the time the annuity was purchased on January 1, 2006.

Unequal Payments Example: A 60-year-old woman purchases an annuity on March 13, 2007 which is to be paid over 10 years with a balloon payment in the tenth year. The annuity names the State of West Virginia as the remainder beneficiary and is considered an uncompensated transfer of resources since it does not provide for equal monthly payments.

Retirement Annuity Example: A 65-year-old woman retired from a company on December 21, 2007 with an annuity that was purchased by the employer as part of her bona fide retirement plan. The annuity is not considered an uncompensated transfer of resources since it was purchased on her behalf as part of her bona fide retirement plan.

24.8.2.E.3 Annuity-Related Transactions Other Than Purchases

➢ *Transactions Subject to Penalty*

Certain annuity-related transactions, which occur on or after March 1, 2009, are subject to a transfer penalty. These transactions include any action taken by the individual that changes the course of payments to be made by the annuity or the treatment of the income or principal of the annuity. These actions include, but are not limited to:

- Additions of principal
- Elective withdrawals
- Requests to change the distribution of the annuity
- Elections to annuitize the contract and other similar transactions

NOTE: Certain annuity-related transactions which occur on or after March 1, 2009 are subject to the policy implementation of the DRA.

Multiple penalties can be applied to the same annuity under certain circumstances.

Multiple Penalty Example: A 60-year old woman served a six-month penalty period because the annuity did not provide equal monthly payments. She became eligible for LTC services payments, but three months later she made an elective withdrawal from the annuity. Another transfer of resources occurred and a penalty is applied.

➢ *Transactions Not Subject to Penalty*

Annuities purchased prior to March 1, 2009 which experience routine events and automatic changes that do not require any action or decision by the individual after March 1, 2009 are not subject to a transfer penalty. Routine changes include notification of an address change, death or divorce of a remainder beneficiary and other similar circumstances. Automatic changes are based on the terms of annuity which existed prior to March 1, 2009, and which do not require a decision, election or action by the individual to take effect. Changes beyond the individual's control, such as a change in law, a change in the policies of the issuer, or a change in the terms based on other factors, such as the issuer's economic condition, are not considered transactions that result in imposition of a transfer penalty.

Annuities and annuity-related transactions that are not subject to a penalty are still subject to applicable income and/or asset policies.

24.8.2.F Transfer to Pay for Personal Care Services

24.8.2.F.1 Non-permissible Transfer of Resources to Pay for Personal Care Services

Personal care services provided to an individual by a relative or friend are presumed to have been provided for free, at the time rendered, when a Personal Care Contract (PCC) did not exist. Therefore, a transfer of resources from an individual to a relative or friend for payment of personal care services is an uncompensated transfer without FMV received for the transferred resource and subject to a penalty, unless the services were provided in accordance with the requirements below. See Section 24.8.2.A.1 regarding FMV.

24.8.2.F.2 Permissible Transfer of Resources to Pay for Personal Care Services

A transfer of resources by an individual to a relative or friend to pay for personal care services rendered may be a permissible transfer if the personal care services were performed through an eligible PCC, also known as a personal care agreement or personal service contract. The PCC must meet all of the following criteria.

➢ *Requirements Regarding the Contract*

The following describes the requirements regarding the contract:

- A PCC exists between the individual or his authorized representative and the caregiver.

- The duration of the PCC is actuarially sound.
- The terms of the PCC are in writing between the individual or his authorized representative and the caregiver.
- The PCC is reviewed by the Worker for compliance;
- The terms of the Contract include:
    1. A detailed description of the services provided to the individual in the home;
    2. The frequency and duration of the services provided. The services must be measurable and verifiable and the compensation to the caregiver paid at a reasonable amount of consideration, i.e., money or property. Payment must be clearly defined either as a set amount or an amount to be determined by an agreed-upon hourly rate that will be multiplied by the hours worked; and,

    NOTE: Reasonable payment is determined by comparing compensation paid by home care agencies, or other independent caregivers, for similar services in the same locale at the specific time period for which services were provided.

    3. Services expected of the caregiver, if any, during any period the individual may reside in an assisted living, skilled nursing, or other type of medical or nursing care facility on a temporary basis between stays at home.

➢ *Requirements Regarding the Provision of Services*

The following describes the requirements regarding the provision of services:

- Services paid from transferred resources must be rendered after the written agreement was executed between the individual and the caregiver;
- A PCC may be in place at the time of the individual's stay in a nursing facility or a similar placement; however, it is assumed, unless proven otherwise, that personal care services during this time are provided by staff rather than the caregiver named in the PCC; and,
- At the time of the receipt of the services, the services must have been recommended in writing and signed by the individual's physician as necessary to prevent the transfer of the individual to residential care or nursing facility care. Such services may not include the mere providing of companionship.

➢ *Requirements Regarding the Transfer*

The following describes the requirements regarding the transfer:

- The transfer to the relative or friend acting as caregiver must have taken place at the time the personal care services were rendered;
- The transfer cannot be for services projected to occur in the future, but must be paid for at the time rendered; and,
- FMV must be received by the caregiver in the form of payment for personal care services provided to him. The Worker must determine if reasonable payment for personal care services occurred.

If the amount transferred to pay for personal care services is above FMV, the amount transferred in excess of FMV is subject to a transfer penalty.

> **Allowable PCC Example:** Mr. Daisy applies for Medicaid. He transferred $5,000 to his granddaughter to pay for personal care services provided to him for the last five months. The Worker reviews the PCC and contacts a community agency representative who indicates the payments made were similar to the rate paid by agencies at the same time period in the same locale. Since the payment was reasonable and the PCC meets all the criteria required in Section 24.8.2.F, the $5,000 was a permissible transfer of resources for payment of personal care services and no penalty is applied.
>
> **Personal Care When in Facility Example:** Since June 2015, Mr. Sage had a PCC in place that meets all of DHHR's requirements. On April 1, 2016, he is admitted to a LTC facility with all personal care services provided. Any transfer of resources to pay for personal care services rendered after April 1, 2016 would be subject to a transfer penalty.
>
> **Payment for Future Services Example:** Mrs. Lily has a compliant PCC with payments stipulated to occur at the end of the month after personal care services are rendered. On February 27, 2016, Mrs. Lilly transferred $3,000 to her daughter for payment for services at $1,000 per month for January through March 2016. Since payment for March is for projected services, $1,000 of the payment is subject to a transfer penalty.
>
> **PCC while in Temporary Placement Example:** Mrs. Hydrangea has a compliant PCC in place but is admitted to a LTC facility on a temporary basis for special treatment. The PCC remains in place; however, from the date of her admission, since personal care services are provided by the facility staff, only transportation to the facility is a service for which she can pay her caregiver if transportation is included in the terms of her PCC.

24.8.2.G Purchase of a Promissory Note, Loan, or Mortgage

Any purchase of a note, or any loan or mortgage is treated as an uncompensated transfer unless all of the following criteria are met:

- The repayment terms must be actuarially sound, based on the Period Life Table found in Appendix D;
- Payments must include the institutionalized spouse/individual in equal amounts during the term of the loan, with no payment deferrals or balloon payments; and,
- The note, loan or mortgage must prohibit cancellation of the debt upon the death of the lender.

If all of the criteria listed above are not met, the loan is treated as a transfer of resources. The amount of the transfer is the entire outstanding balance due on the loan as of the month of application for Medicaid LTC services.

See Section 5.5 to determine if the loan, mortgage/land sale contract, or promissory note is an asset.

24.8.2.H Treatment of Transfer of a Stream of Income or Right to a Stream of Income

When the client fails to take action necessary to receive income or transfers the right to receive income to someone else for less than CMV, the transfer of resources penalty is applied. The Worker must follow the steps described below.

Step 1: Verify the amount of potential annual income.

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

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

Step 4: Divide the Step 3 amount by the average monthly nursing facility private pay rate of $9,930 to determine the penalty period.

NOTE: A partial month's penalty is imposed for the transfer of an individual or single income payment that is less than the monthly nursing facility private pay rate. See Transfer Penalty Section below for instructions about how to determine and apply partial month penalties.

24.8.2.I Treatment of Jointly-Owned Resources

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

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

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

24.8.2.J Transfer Penalty

The transfer of resources penalty is a period of ineligibility for:

- Nursing facility services; and
- A level of care in any institution, equivalent to that of nursing facility services.

The client may remain eligible for Medicaid, but only services not subject to a penalty are covered. Home and community based waiver groups will not continue their Medicaid eligibility during the transfer penalty, but will be evaluated for other coverage groups.

The penalty is applied as follows.

24.8.2.J.1 Start of the Penalty

The beginning date of each penalty period imposed for any uncompensated transfer of resources is the later of:

- The date on which the individual is eligible for and is receiving institutional level of care services that would be covered by Medicaid if not for the imposition of the penalty period; OR
- The first day of the month after the month in which assets were transferred and advance notice expires, when the individual receives LTC Medicaid; AND
- Which does not occur during any other period of ineligibility due to a transfer of resources penalty.

➢ *Penalty for Transfers during the Look-Back Period*

When resources have been transferred at singular or multiple points during the look-back period, add together the value of all resources transferred, and divide by the average cost to a private-pay patient of nursing facility services. This produces a single penalty period which begins on the earliest date that would otherwise apply, if the transfer had been made in a single lump sum.

▪ *Penalty for Transfers during the Look-Back Period Examples*

> **Example 1:** Mr. Ivy enters the nursing facility and applies for Medicaid in October 2019. The individual transferred $50,000 in April 2019. Based on the average private pay nursing facility rate of $9,930 a month, the penalty is five whole months, beginning October 2019 when Mr. Ivy was otherwise eligible for and receiving an institutional level of care that would have been covered by Medicaid, if not for the imposed penalty. A partial month's penalty of $350 is imposed for March 2020. Mr. Ivy is required to pay this amount to the nursing facility, in addition to the calculated monthly contribution. See Length of Penalty below.
>
> **Example 1.1:** Same situation as above, but during the penalty period the Worker discovers an additional, undisclosed transfer that occurred during the look-back period. The penalty period is recalculated to include the undisclosed transfer of resources.
>
> Example 2: Ms. Fern enters a nursing facility in January 2019 and applies for Medicaid in October 2019 with a request for backdated coverage to August 2019.

Ms. Fern transferred $19,000 in January 2019, $19,000 in February 2019 and $19,000 in March 2019. The Worker must calculate the penalty period by adding the transfers together. The total of $57,000 is divided by the nursing facility cost of $9,930. The penalty period is five whole months, beginning in August 2019, because the individual requested backdated coverage to August 2019, and was otherwise eligible for and receiving institutional level of care that would have been covered by Medicaid, if not for the imposed penalty. A partial month's penalty for January 2020 of $7,350 is also imposed. Ms. Fern is required to pay this to the nursing facility, in addition to his calculated monthly contribution. See Length of Penalty below for partial month penalties.

Example 2.1: Same situation as above, but after the penalty period ends and Ms. Fern is receiving Medicaid, the Worker discovers an undisclosed transfer occurred during the look-back period. A penalty is assessed and advance notice of an additional transfer penalty is sent to Ms. Fern.

➢ *Transfers During a Penalty Period*

When an individual is in a penalty period and transfers additional resources during the penalty, a new penalty period begins as soon as the previous penalty ends.

All penalties for resources transferred on or after March 1, 2009 run consecutively.

▪ *Transfers During a Penalty Period Examples*

Example 1: Mr. Oak transfers $70,000 and is serving a seven-month penalty beginning October 2019 through April 2020 with a partial month's penalty of $490 for May 2020. In November 2019, Mr. Oak receives an inheritance of $10,000 which he gives to a nephew. There is an assessed penalty of one whole month and a partial month's penalty of $70. The new penalty begins May 2020.

Example 2: Ms. Orchid, approved for and receiving institutional level of care services, receives an inheritance of $100,000 in 2019 and gives the money to her grandson. Advance notice of the transfer penalty is sent in November and the penalty period begins December 1, 2019.

24.8.2.J.2 Length of Penalty

There is no maximum or minimum number of months a penalty may be applied. The penalty runs continuously from the first day of the penalty period, whether or not the client leaves the institution.

A partial penalty or extra payment is only applied in the last/partial month of the penalty period.

The penalty period lasts for the number of whole and/or partial months determined by the following calculation:

- Total amount transferred during the look-back period divided by the State's average, monthly nursing facility private pay rate of $331 per day or $9,930 per month.
- When the amount of the transfer is less than the average monthly private pay cost of nursing facility care, the agency imposes a penalty for less than a full month. The partial month's penalty is converted to a dollar amount and added to the individual's calculated contribution to his cost of nursing facility care for his first month of eligibility.

The partial month's penalty is determined as follows:

Step 1: The total amount transferred is divided by the State's average monthly nursing facility private pay rate of $9,930.

Step 2: Multiple the number of whole months from Step 1 by the average private pay rate of $9,930.

Step 3: Subtract the amount in Step 2 from the total amount of all transfers. The remainder is the amount which is added to the individual's calculated contribution.

> **Penalty Calculation Example:** Mr. Cactus makes an uncompensated transfer of $24,534 in the month of application for Medicaid coverage of nursing facility services.
>
Step 1:	$24,534	Uncompensated transfer amount
	÷ $9,930	State's average monthly nursing facility private pay rate
	2.47	Number of months for penalty period
Step 2:	$9,930	State's average monthly nursing facility private pay rate
	x 2	Whole months in penalty period
	$19,860	
Step 3:	$24,534	Total uncompensated transfer amount

-$19,860	Amount for three whole months in period
$4,674	Partial month's penalty amount

If Mr. Cactus applies in July and is otherwise eligible, the penalty period runs for two full months from July through August, with a partial month's penalty calculated for September of $4,674. The September partial month's penalty amount of $4,674 is added to the calculated September contribution for his cost of care. If Mr. Cactus had a $500 monthly contribution, he would be required to pay $5,174 for the cost of care in September.

24.8.2.J.3 Who Is Affected by the Penalty

The institutionalized client is affected by any transfer described above when he or his spouse or any entity acting on their behalf or at their direction transfers an asset.

When the three following conditions are met, any remaining penalty period is divided equally between the institutionalized person and spouse:

- The spouse transferred resources which resulted in ineligibility for the institutionalized client;
- The spouse either is eligible for or applies for Medicaid and is, then, an institutionalized individual; and,
- Some portion of the penalty against the original institutionalized spouse remains when the above conditions are met.

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

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

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

A recording in each affected case must specifically explain the division of the penalty period.

Division of the Penalty Period Example 1: Mr. Aster enters a nursing care facility and applies for Medicaid. Mrs. Aster transfers a resource that results in a 36-month penalty against Mr. Aster. After 12 months into the penalty period, Mrs. Aster enters a nursing care facility and becomes eligible for Medicaid. The penalty period against Mr. Aster still has 24 months to run.

Because Mrs. Aster is now in a nursing care facility, and a portion of the original penalty period remains, the remaining 24 months of the penalty must be divided equally between Mr. and Mrs. Aster.

Division of the Penalty Period Example 2: Mr. Juniper is in a nursing facility and applies for Medicaid. Two months before his application he transferred resources to become eligible for Medicaid and a 10-month penalty begins. Two months into the penalty, Mrs. Juniper refuses an inheritance left to both of them because she is afraid it will adversely affect his future eligibility for nursing care coverage. The next month, Mrs. Juniper becomes eligible for HCBS. The Worker inquires about resource transfers and is told about the refusal of the inheritance. This is a transfer of resources. A penalty period is determined to be 12 months. Mr. Juniper continues to serve his 10-month penalty. The other penalty period begins the month after the 10-month period ends. His second penalty lasts six months (half of the 12-month period for his wife's transfer of their resource). Mrs. Juniper receives a six-month penalty period which begins the month she is otherwise eligible to receive an institutional level of care.

➢ *Application of the Penalty*

The only penalty for transferring resources is delayed or lost eligibility for nursing facility, ICF/IID, or Home and Community Based Waiver care. The client is approved, if otherwise eligible, for any other applicable Medicaid coverage group.

24.8.3 HOMESTEAD PROPERTY EXCLUSION

A nursing facility resident is entitled to an exclusion of his homestead as a countable asset as long as he has intent to return to his homestead when/if discharged. It is not necessary that the client be medically able to return home to apply the exclusion. It is totally based on the client's intended actions, not whether he has the ability. The property to which the person intends to return must be the principal place of residence in which he resided before he went into the nursing facility. Principal place of residence is considered to be the person's primary residence and is typically the address used on a driver's license, for voting, and for tax purposes. If the client's homestead is a multi-unit dwelling, such as an apartment building, the entire property is excluded, not just the portion of the value which corresponds to the portion of the property in which he actually lived. When the client does not have intent to return due to domestic abuse, see Section 5.5.

The homestead property need not be in West Virginia. The homestead exclusion applies, regardless of the state in which it is located. The client's expressed intent to return to the homestead property does not necessarily affect his West Virginia residency. See Chapter 2 for residency details.

When the client's spouse or dependent relative resides in the primary residence, the homestead property remains excluded, regardless of the client's intent to return.

For purposes of the homestead exclusion only, a dependent relative is one who is dependent financially, medically or as otherwise determined dependent upon the institutionalized person, and includes a child, stepchild or grandchild; parent, stepparent or grandparent; aunt, uncle, niece or nephew; brother or sister, including relations of the step or half, cousin or in-law.

When the home is rented or vacant this has no bearing on the homestead exclusion, however, when the individual places his home on the market, intent to return no longer exists and home is not excluded.

When the client is incapable of indicating his intent, his Committee, legal representative or the person handling his financial matters will make the determination. The Worker must record the client's statement or intent in the case record. A written statement may be requested but no action may be taken to deny or stop benefits for failure to provide a written statement when the client has expressed his intent verbally or by gesture.

24.8.4 HOME EQUITY

When the equity value of an individual's home exceeds the current maximum allowable amount, he is ineligible for Medicaid payment for nursing facility or waiver services, unless his spouse, child under 21, or disabled adult child resides in the home. The current maximum allowable equity value is $595,000. Denial of LTC Services due to excessive home equity is subject to the Undue Hardship Waiver Provision.

24.8.5 Long Term Care Insurance Partnership (LTCIP) ASSET DISREGARD

24.8.5.A Introduction and Purpose

West Virginia's participation in the LTCIP is established by §9, Article 4E-1 of the West Virginia State Code. The LTCIP Asset Disregard results from a combined effort between Centers for Medicare and Medicaid (CMS), DHHR, LTC insurers, and the West Virginia Insurance Commission in accordance with Section 1917 of the Social Security Act. The LTCIP Asset Disregard provides an incentive to individuals to provide for their own LTC needs through the purchase of a Qualified LTCIP Policy, while protecting their assets.

24.8.5.B Definitions

For purposes of the LTCIP Asset Disregard only, the following definitions apply.

LTCIP ASSET DISREGARD

An asset disregard available to only individuals in the Nursing Facility coverage group, but whose resources exceed the allowable asset limit. Eligible individuals must have a Qualified LTCIP Policy issued by a Partnership State while residing in a Partnership State, with insurance payments made as of the date of the State's State Plan Amendment (SPA) that implemented the LTCIP. Assets are disregarded dollar-for-dollar in the amount of insurance payments made. Assets are protected at Estate Recovery in this same amount.

LTCIP POLICY VERIFICATION (OFS-LTCIP-1)

This form is given to the applicant for completion by the individual's insurance carrier or other individual who can attest to the policy's details and benefits paid. Other sources of verification are the Qualified LTCIP Policy, letter from the issuing state's governmental agency that regulates insurance, or verification from the issuing insurance agency indicating compliance of the Policy with Section 1917(b)(5)(A) of the Social Security Act.

PARTNERSHIP (QUALIFIED) STATES

States that are participating in the LTCIP. Each Partnership State has an approved State Plan Amendment (SPA) that indicates the date the State implemented the LTCIP. West Virginia's SPA implemented the LTCIP as of July 1, 2010.

QUALIFIED LTCIP POLICY

An LTC Policy that meets certain requirements of federal and state law. These policies are issued by Partnership (Qualified) States as of the date the State implemented the LTCIP.

RECIPROCITY

A reciprocal relationship exists between Partnership States that allows a resident with a Qualified LTCIP Policy in one Partnership State who later moves to another Partnership State, the same asset protection he previously had.

24.8.5.C Individuals Who May Receive the LTCIP Asset Disregard

The LTCIP Asset Disregard is available to only individuals in the Nursing Facility coverage group but whose individual resources exceed the asset limit.

24.8.5.D Verifications Required

When an individual states he has an LTC policy that has paid insurance benefits to him or on his behalf, the Worker evaluates him for the LTCIP Asset Disregard.

24.8.5.D.1 Verification of Client's Residency and Status of Policy-Issuing State at the Policy's Issuance

To be eligible for the LTCIP Asset Disregard, the policy owner must have been a resident of a Partnership State AND the issuing State must have been a Partnership State at the time the policy was issued.

- When a West Virginia resident verifies ownership of a Qualified LTCIP Policy issued by a West Virginia insurer or another Partnership State with an issuance date on or after July 1, 2010 and the individual verifies insurance payments made to him or on his behalf as of that same date, his individual resources may be disregarded dollar-for-dollar in the same amount as the insurance payments made. His resources are protected in this same amount at Estate Recovery.

  > **Partnership State Example 1:** Mrs. Balsam applies for Medicaid on October 16, 2011 and states she has a West Virginia-issued LTC policy that has been paying

insurance benefits to her since her institutionalization in August 2011. Her OFS-LTCIP-1 indicates her policy was purchased on April 1, 2010. Mrs. Balsam has an LTC policy but it is not a Qualified LTCIP Policy since West Virginia was not a Partnership State until July 1, 2010. Mrs. Balsam's assets cannot be disregarded.

Partnership State Example 2: Mr. Zinnia is a lifelong West Virginia resident. He owns a Florida-issued Qualified LTCIP Policy purchased January 1, 2009 which is after the date Florida became a Partnership State (January 1, 2007). West Virginia became a Partnership State on July 1, 2010. Therefore, since Mr. Zinnia was not a resident of a Partnership State when his policy was issued, he is ineligible for the LTCIP Asset Disregard.

Partnership State Example 3: Mr. Begonia is a lifelong West Virginia resident. He purchased a Qualified LTCIP Policy from Minnesota on September 1, 2010 and applied for Medicaid on February 11, 2011. Since Minnesota became a Partnership State on July 1, 2006, his Policy was issued by a Partnership State at the time of purchase and he was also a resident of West Virginia, another Partnership State at that time; therefore, as long as he verifies insurance payments made after July 1, 2010, he is eligible for the LTCIP Asset Disregard to be applied to his individual resources in the amount of insurance payments made.

- When a West Virginia resident was a former resident of a Partnership State and purchased a Qualified LTCIP Policy issued by that state, as long as his policy was issued as of the date of his former State's SPA that implemented the LTCIP and insurance payments occurred as of that same date, he is afforded the same asset protection he previously had prior to becoming a West Virginia resident. The policy's benefits need not be exhausted before the LTCIP Asset Disregard is applied.

Partnership State Example 4: Mr. Violet was a resident of Virginia before establishing West Virginia residency in January 2011. He purchased an LTC policy from Virginia on May 1, 2007 (the same day Virginia became a Partnership State). Mr. Violet verifies being institutionalized in Virginia and his $62,000 in assets were disregarded due to insurance payments paid on his behalf in 2009 and 2010 that exhausted his $75,000 Policy. His assets continue to be protected by the LTCIP Asset Disregard and he is eligible for West Virginia Medicaid.

- When an individual exchanges a Qualified LTCIP Policy issued by his former state of residence for a West Virginia policy, eligibility for the LTCIP Asset Disregard is evaluated based on the first State's SPA, policy issuance date and dates of insurance payments made.

Partnership State Example 5: Mr. Carnation was formerly an Ohio resident. He exchanges his Ohio-issued Qualified LTCIP Policy for a West Virginia-issued

Policy. He is evaluated for the LTCIP Asset Disregard based on the circumstances surrounding the first policy's issuance. Ohio became a Partnership State on September 1, 2007. His Policy was issued on January 1, 2008 and insurance benefits were made after this same date; therefore as long as insurance payments made on his behalf equal or exceed his individual resources, the LTCIP Asset Disregard can be applied.

24.8.5.D.2 Verification of the Qualified LTCIP Policy

The LTCIP Asset Disregard requires that the LTC policy be a Qualified LTCIP Policy. The OFS-LTCIP-1 is used to verify information about the individual's policy.

The following criteria are used to determine if the policy is qualified for the Disregard:

- The individual was a resident of a Partnership State when his policy was issued; AND

NOTE: When an individual exchanges his Qualified LTCIP Policy issued by his former state of residence for a West Virginia policy, eligibility for the LTCIP Asset Disregard is evaluated based on the first State's SPA date, policy issuance date, and dates of insurance payments made.

- The policy meets the Internal Revenue Service's (IRS) Code of 1986 requirements related to the LTCIP; AND
- The policy's issuance date was no earlier than the effective date of the issuing Partnership State's SPA that implemented the LTCIP; AND
- The policy meets the specific rules of the National Association of Insurance Commissioners (NAIC); AND
- The policy includes the inflation protection based on the age of the insured at the time of purchase.

NOTE: Changes made to the LTCIP Policy after issuance will not affect the LTCIP Asset Disregard as long as the policy continues to be Qualified.

NOTE: The LTCIP Asset Disregard is not revoked if a State withdraws from the Partnership.

LTCIP Policy Example: Mr. Fern states he has an LTC policy that has paid him $35 per day for each day of his institutionalization and he requests the LTCIP Asset Disregard applied to his $3,000 in excessive assets. Mr. Fern provides the Worker with a copy of his policy. The policy does not indicate compliance with

> the IRS Code nor does it address inflation protection. The policy is not a Qualified LTCIP Policy and the applicant is ineligible for the Disregard.

24.8.5.D.3 Verification of Qualified LTCIP Insurance Benefits Paid

The OFS-LTCIP-1 is used to obtain information about the dates of, amount of Qualified LTCIP insurance benefits paid, and the remaining benefits available to the individual. When the individual does not complete this form, the Worker must verify the amount of insurance benefits paid to or on behalf of an individual as of July 1, 2010 when the individual is a West Virginia resident with a West Virginia-issued Qualified LTCIP Policy or owns a Qualified LTCIP Policy issued from another Partnership State.

24.8.5.E The Amount of the LTCIP Asset Disregard

Resources are disregarded dollar-for-dollar as the amount paid out by the insurance company.

24.8.5.F Applying the LTCIP Asset Disregard at Application and Redetermination

24.8.5.F.1 Applying the Disregard at Application

When there is a community spouse, the countable assets of the couple are combined and the asset assessment is completed. The LTCIP Asset Disregard is applied to the individual's assets at eligibility determination.

The amount of the Disregard is determined by the value of payments made to the individual or on his behalf since July 1, 2010. The policy's benefits need not be exhausted for the LTCIP Asset Disregard to be applied. The resource(s) to which the Disregard is applied may be disregarded in part or in entirety.

When a resource is disregarded in its entirety, the Worker indicates in the eligibility system that the resource is inaccessible and details in case comments that the LTCIP Asset Disregard was applied. The corresponding insurance payments made, date of last payment and the amount of benefits remaining in the policy are documented to track the assets that were protected.

> **LTCIP Asset Disregard at Application Example:** Ms. Tulip is eligible for the Disregard. She has a bank account with a balance of $27,000. Insurance benefits from her Qualified LTCIP Policy totaling $27,000 have been paid to her. In the eligibility system, an account totaling $27,000 is entered and listed as inaccessible. The Worker documents the application of the Disregard, dates of payments made that resulted in her becoming eligible for Medicaid and the amount of benefits remaining under Ms. Tulip's policy.

An asset to which the LTCIP Asset Disregard is applied in part and results in eligibility being established is entered in the data system as two assets, one inaccessible and one with the remaining value after the Disregard is applied. Documentation is detailed in case comments.

> **Partially Accessible Asset Example:** Mr. Daffodil has $12,000 in a savings account. He has a West Virginia-issued, Qualified LTCIP Policy that was purchased on August 1, 2010. The Worker verifies the policy has paid out $10,000 on Mr. Daffodil's behalf since that same date. The Worker applies the Disregard and enters a $10,000 savings account as inaccessible and then enters the remaining $2,000 as accessible in the eligibility system. The Worker details the information in case comments.

As long as the individual's assets remain the same, the protection of the resources that resulted in the client's eligibility continues throughout the client's Medicaid periods of eligibility. See below for policies governing when the individual's resources increase in value or he transfers a resource for less than the FMV.

NOTE: Even though a client is eligible for the Disregard and Medicaid, a determination is necessary regarding to whom the LTCIP insurance payment is made. The Worker must determine if the payments are income to the client or a third-party payment. If paid to the client, it is counted as income. If paid to the nursing facility, it is considered a third-party payment.

NOTE: If the client is applying for other benefits, the eligibility system's asset screens are re-evaluated in accordance with each program's requirements and the absence of the Disregard.

24.8.5.F.2 Applying the Disregard at Redetermination

The Worker must track the assets of the client, insurance payments made to or on the client's behalf, and assets disregarded since the previous application.

Medicaid eligibility is reevaluated when the client reports transferring a previously disregarded asset, obtaining an additional asset, or an asset increasing in value.

A transfer of an asset that was previously disregarded is not subject to a transfer penalty.

If the value of the client's assets increase or the client obtains an additional countable asset that causes him to exceed the allowable asset amount, he will need to verify additional payments made on his behalf by the LTCIP Policy in addition to the amount of payments that were previously used to disregard the assets that were transferred. Additionally, the amount of the client's estate that was protected from Estate Recovery is reduced by the same amount as the value of the asset that was transferred.

> **LTCIP Disregard at Redetermination Example:** Mr. Tansy is in a nursing facility. On September 1, 2010, Mrs. Tansy applied for LTC services for her husband. The couple's assets are combined at asset assessment and the spousal share is attributed to Mrs. Tansy. Mr. Tansy's income is less than 300% of the SSI payment for one, but he has $10,000 in individual assets consisting of $5,000 in an accessible money market account and $5,000 in stocks. He is asset-ineligible for LTC by $10,000. He verifies ownership of a $100,000 Qualified LTICP Policy which he purchased on July 12, 2010. The Worker verifies the policy's status and that his policy has paid for his care in July and August, paying $10,000 to the nursing facility. The Worker disregards his money market and stocks and Medicaid eligibility is effective September 1, 2010.
>
> At redetermination, Mrs. Tansy reports transferring the stock to their son. The transfer is not subject to a penalty since the asset was previously disregarded. However, since insurance payments verified as paid by the LTCIP Policy on behalf of Mr. Tansy were applied to disregard the value of the stock, and resulted in Mr. Tansy being eligible for Medicaid, these same insurance payments cannot be used again to disregard other assets. Should Mr. Tansy's money market increase in value or the he acquire additional countable assets, he must verify additional payments by the insurance company before any other assets can be disregarded.
>
> Mr. Tansy's amount of assets that were protected at Estate Recovery is also reduced from $10,000 to $5,000 since the previously disregarded stock was transferred to his son.

NOTE: If the client is no longer eligible for Medicaid under the 300% gross income test, his eligibility for other Medicaid groups is evaluated prior to closure and the eligibility system's asset screens are re-evaluated in accordance with each program's requirements and the absence of the LTCIP Asset Disregard.

24.9 NOTIFICATION AND FORMS

The applicant or his authorized representative must be notified in writing of the action taken on his application using form DFA-NL-A. The client, his authorized representative, and the nursing facility administrator must be notified in writing in advance of any action that results in a change in the level of benefits using the appropriate form. See Chapter 9 for general notification requirements. This section discusses additional notification procedures related to nursing facility cases.

24.9.1 NOTIFICATION TO CLIENT, AUTHORIZED REPRESENTATIVE, OR NURSING FACILITY

Any time the client or his authorized representative is notified of any changes in the client's eligibility, the nursing facility administrator must also be notified. If more than one nursing facility is involved, each administrator must be sent a copy of the ES-NH-3.

Below is a table of forms referenced in this chapter. It shows the form number, name, and description. The form number can vary on eligibility system generated notices.

Form	Name	Description
DFA-2	Application for Benefits	Application for benefits that can be used by all eligibility groups
DFA-5	Document for Protection of Application Date	When the applicant has completed the application, and there is a technical failure that prevents printing the DFA-2, Form DFA-5 must be signed by the applicant.
DFA-6	Request for Information	Also called the “verification checklist;” used to inform the applicant of additional information needed.
DFA-10	Appointment Letter for Office, Home, Phone	Notifies the client of the scheduled appointment time and date.
DFA-FH-1	Fair Hearing Request Form	Notifies client of right to fair hearing, often sent with other forms.
DFA-HS-3	Interagency Referral Form	Notifies the Social Security Administration when an SSI recipient enters or leaves a nursing facility.

Form	Name	Description
DFA-LTC-5	Application for Long Term Care Services for Current Medicaid Recipients	Gathers information regarding transferred assets, trusts, and annuities.
DFA-MA-1	Application for LTC Medicaid and CDCSP	A shelf document used to apply for the following Long Term Care (LTC) Medicaid categories: Nursing Facilities Services, Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities, Aged and Disabled Waiver (ADW), Intellectual Disabilities and Developmental Disabilities (IDD) Waiver, Traumatic Brain Injury (TBI) Waiver, and Children with Disabilities Community Service Program (CDCSP). It must only be used for applicants that are not eligible for Medicaid coverage using the Modified Adjusted Gross Income (MAGI) methodology.
DFA-NH-3	Notice of Contribution to the Cost of Care	Along with any appropriate letter, notifies client of initial or changed required contribution. This is also sent to the nursing facility, BMS LTC Unit, and the client or his AR
DFA-NL-A	Notification Letter: Action Taken On Your Application	Notice of decision at application.
DFA-NL-B	Notification Letter: Action Taken On the Benefits You Receive from the DHHR	Notice of decision at redetermination.
DFA-NL-C	Notification Letter: Pending Change in the Benefits You Receive	Notice of decision related to a change in benefits.
DFA-NL-D	Notification Letter: Action Taken on Your Request for an Assessment of the Assets Belonging to Both You and Your Community Spouse	Informs client of results of an asset assessment, whether or not he has formally applied for Medicaid.
DFA-NL-UH-1	Notification of Right to Request an Undue Hardship Waiver	Sent with DFA-FH-1 and DFA-NL-UH-5.
DFA-NL-UH-2	Decision for Request of Undue Hardship	Sent with FH-1 to notify client of UH decision.
DFA-UH-5	Application for Undue Hardship Waiver	Application for undue hardship waiver.

Form	Name	Description
IM-NL-AC-1	Assets Computation and Asset Assessment	Used to complete an asset assessment.
IM-NL-LTC-1	Long Term Care Calculations	Determines eligibility for Nursing Facility coverage group and contribution to cost of care.
IM-NL-LTC-2	Determination of Community Spouse and Family Maintenance Allowance for LTC programs	Calculates allowances for the community spouse and dependent family. Sent with applicable notice of decision form.
OFS-LTCIP	LTCIP Policy Verification	LTC insurance partnership policy verifications for eligibility for LTCIP disregard.

24.10 CASE MAINTENANCE

See Chapter 10 for policies and procedures for the appropriate coverage group.

24.10.1 NURSING FACILITY TRANSFER

When an individual transfer facilities in West Virginia a new Pre-Admission Screening (PAS) form must be obtained. See Section 24.12. See Section 24.9 for notification requirements and Section 24.7.8 for information regarding prorating payments between facilities. If an individual transfers to a nursing facility in West Virginia, his eligibility must be evaluated as any other applicant.

24.10.2 CHANGES REQUIRING REEVALUATION

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

24.10.3 DISCHARGES AND CLOSURES

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

Upon discharge, the Worker must:

- Determine if proration of the client's contribution to his cost of care is applicable. See Section 24.7.4.
- Notify the Bureau for Medical Services (BMS) Long Term Care (LTC) Unit.
- Take the appropriate data system action.
- If losing Medicaid coverage, evaluate the client for all Medicaid coverage groups.

24.11 BENEFIT REPAYMENT

24.11.1 CLIENT REPAYMENT

When payment for nursing care services is made for a client who is ineligible for such payment, for a lower amount, or for Medicaid, repayment is pursued as specified in Chapter 11.

24.11.2 PROVIDER FRAUD

When fraud on the part of a nursing facility or other Medicaid provider is suspected, the procedures in Chapter 11 are followed.

24.11.3 ESTATE RECOVERY

West Virginia has the authority to place liens on the estate or property of a Medicaid client who is either in a nursing facility or who receives benefits under a home and community-based waiver program, and who is age 55 or older, or who is determined to be permanently institutionalized. These liens cannot force the sale of real property during a person's lifetime.

The state will not impose a lien or will defer recovery from the estate when the individual qualifies for Medicaid under the Adult Group expansion provisions of the Affordable Care Act (ACA).

The Bureau for Medical Services (BMS) contracts with an agency to accomplish the recovery and to answer questions from interested persons. When the Worker receives inquiries about Estate Recovery, the Worker must refer the client to the current contract agency. Information about this agency is found in Appendix E. The Worker must not contact the contract agency on behalf of the client.

See Section 24.6 regarding the Long Term Care Insurance Partnership (LTCIP) Asset Disregard and its relation to Estate Recovery.

24.12 ESTABLISHING APPLICANT AS AGED, BLIND, OR DISABLED AND THE MEDICAL NECESSITY FOR NURSING FACILITY CARE

24.12.1 ESTABLISHING MEDICAID CATEGORICAL RELATEDNESS

When the applicant for nursing facility services is not a Medicaid client under a full Medicaid coverage group, categorical Medicaid eligibility and financial eligibility must be established for the Nursing Facility coverage group or the SSI-Related/Monthly Spenddown group.

Disability or blindness, when not already established by the receipt of Retirement, Survivors, and Disability Insurance (RSDI) or Railroad Retirement benefits based on disability, must be established by the Medical Review Team (MRT).

All procedures in Chapter 13 for an MRT referral for the appropriate coverage group are applicable, and a presumptive approval may be made according to the guidelines in Chapter 13.

The Pre-Admission Screening (PAS) does not by itself establish disability. However, a copy of the PAS may be submitted to the MRT as medical information.

24.12.2 ESTABLISHING MEDICAL NECESSITY, THE PAS

24.12.2.A General Requirements

Before payment for nursing facility services can be made, medical necessity must be established for all clients. The PAS is the tool used for this purpose. The PAS is signed by a physician and then evaluated by a medical professional working with the State's contracted level of care evaluator. The PAS is valid for 60 days from the date the physician signs the form, which is the only date used for establishment of medical necessity. The 60-day validity period applies, regardless of the reason for the completion. See below for situations when a PAS is not completed and payment for nursing facility care is requested for a prior period.

When the PAS indicates the client is not in need of nursing facility care, the application for Medicaid, unless withdrawn, is processed for any other coverage group for which the person qualifies, and all client notification procedures apply.

When the client no longer has medical necessity for long term care services, the nursing facility must notify the Worker.

There is no requirement that the name of the facility in which the client resides appear on the PAS.

24.12.2.B When the PAS Must Be Completed

For Medicaid to pay for nursing facility services, the PAS must be completed when:

- The client enters a Medicaid-certified nursing facility.
- The client transfers from one facility to another, even when the client moves from one facility to another governed by the same corporation, and even when 60 days has not passed since the completion of the PAS for the first facility.
- The client is admitted to an acute care facility and returns to the same nursing facility after 60 days.
- The client's condition changes to the extent that he no longer requires nursing facility services.
- Nursing facility care is approved for a limited time, a new PAS must be submitted by the facility before the end of the approved period.
- A private-pay patient applies for Medicaid, unless an approved PAS was completed within 60 days prior to the application.

This applies even if a PAS certifying medical need was completed at the time of admission to an approved facility. This also applies if a PAS was completed any other time before 60 days prior to the application. The new PAS certifies current need for nursing facility services.

A previously approved PAS may be used for backdated eligibility and payment for nursing facility services, so long as the client has remained in the same facility since completion of the previously approved form.

24.12.2.C Date of PAS Examples

> **Example 1:** Mr. Rose enters a nursing facility as a private pay patient on October 18, 2016, and a PAS, which certifies his need for nursing care, is completed on that date. On February 1, 2017, he is still in the same nursing facility, and his family applies for Medicaid for his nursing facility care. Because the PAS completed at admission is more than 60 days old on February 1, 2017, a new PAS must be completed. If otherwise eligible, payment for services begins February 1, 2017.
>
> **Example 2:** Mr. Begonia enters a nursing facility on September 2, 2016, and a PAS which certifies his need for nursing facility care is completed on that date. On September 30, 2016, his family takes him home to care for him. On October 16, 2017, his family places him in another facility and applies for Medicaid for his nursing care. A new PAS is required because he left the nursing facility for which the PAS was originally completed, and the new facility must have an original approved PAS.
>
> **Example 3:** Mr. Calla enters a nursing facility on March 7, 2016, and a PAS, which certifies his need for nursing care, is completed on that date. On September 9, 2017, he is still in the same facility, and his family applies for Medicaid for his nursing care. They request payment for his care beginning June 1, 2017. Because the admission PAS, although approved, was completed more than 60 days prior to September 9, 2017, a new PAS must be completed. The approved PAS, completed March 7, 2016, is used to certify his need for nursing facility care from June 1, 2017, until the date of the newly approved PAS.

24.12.2.D Temporary Stays in Distinct Parts

Distinct part, as used in the following, means the part of the acute facility which provides nursing facility services.

When a nursing facility client is admitted to an acute care facility, moves to a distinct part of the facility, and then returns to the original nursing facility, special PAS requirements may apply.

The special PAS procedures are as follows:

- When the client moves from the acute care facility to a Medicare-only distinct part, no new PAS is required for the distinct part. However, a new PAS is required when the client returns to the original nursing facility.

- When the client moves from the acute care facility to a distinct part which is dually certified for Medicare and Medicaid, two PASs are required, one when the client enters a distinct part and another when he returns to the original nursing facility.

The table below shows when a PAS must be completed for stays in distinct parts.

Type of Distinct Part	Move to Distinct Part	Return to Nursing Facility
Medicare-only Distinct Part	Not required	Required
Dually certified for Medicare and Medicaid	Required	Required

24.12.2.E Procedures Related to the PAS

24.12.2.E.1 Who Completes the PAS

The provider completing the PAS may include, but is not limited to, a hospital, physician, nursing facility, or waiver agency.

24.12.2.E.2 Responsibilities of the Completing Provider

Responsibilities of the completing provider include:

- To submit the PAS to the level of care evaluator employed by the State's contract agency for review See Appendix E; and
- Once the review has been completed, to submit the original, reviewed PAS, with the admission documentation, to the provider of nursing facility services.

24.12.2.E.3 Responsibilities of the Level of Care Evaluator

Responsibilities of the level of care evaluator include:

- To determine the client's need for and level of care and to evaluate for the presence of mental illness or intellectual disability;

- To return the original form, with the review determination, to the originating provider. The possible review results are:
    - A = Nursing care needed
    - B = Personal care needed
    - C = No services needed
- To forward the original PAS to the appropriate agency for the Level II evaluation when the presence of mental illness or intellectual disability is indicated. See below.

24.12.2.E.4 Responsibilities of the Worker

Responsibilities of the Worker include:

- To forward the original PAS to the level of care evaluator when the PAS completer sends to the county office instead of the level of care evaluator.
- To obtain a signed copy of the current, approved PAS as verification of medical necessity at application and redetermination.

A new PAS is only required in the situations described above. A new PAS is not required at each redetermination. However, the Worker must verify that the client remains medically-eligible by obtaining a copy of the current PAS on file with the nursing facility.

> **PAS Example:** Mrs. Ginger completes a redetermination in June 2017. The Worker obtains a copy of the current approved PAS on file with the nursing facility. The PAS is dated May 21, 2016, approved for over six months and Mrs. Ginger has not left the facility since admission. The Worker has verified medical necessity at redetermination.

24.12.2.E.5 Level II Pre-Admission Screening and Annual Resident Review (PASARR)

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

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

24.12.3 ESTABLISHING RETROACTIVE MEDICAL NECESSITY USING PHYSICIAN'S PROGRESS NOTES OR ORDERS

This procedure is used only for backdating eligibility for nursing facility care when no PAS exists for the period for which payment of services is requested. The progress notes or orders cannot be used to change an existing PAS which does not certify need for nursing facility care. Eligibility may only be backdated up to three months prior to the month of application.

In certain circumstances, which may be beyond the control of the client or his authorized representative, a client may be admitted to a Medicaid-certified nursing facility without a PAS. When this occurs and the client applies for Medicaid and payment of nursing facility services for a prior period, the Worker may obtain and use the physician's progress notes or orders in the client's medical records to establish medical need. A valid PAS for current eligibility must still be obtained.

This information is obtained from the nursing facility and the facility may request that the physician add such notes to the client's records. These records may also be used when application is made and payment requested for a deceased client when no valid PAS was completed.

The Worker must record the reason for the use of the progress notes or orders in case comments.

24.13 SPECIAL PROCEDURES RELATED TO COVERAGE GROUPS

Individuals already receiving full coverage Modified Adjusted Gross Income (MAGI) Medicaid, who become eligible for Medicaid payment of nursing facility services, must be dually coded in the data system as receiving nursing home coverage.

24.13.1 SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENTS

The Worker must notify the Social Security Administration (SSA) using the DFA-HS-3 when the SSI recipient enters or leaves a nursing facility.

When the institutionalized SSI recipient has an Essential Spouse (See Chapter 23) who is included in the assistance group (AG) and who appears on the same Medical ID card, the Essential Spouse remains eligible for SSI Medicaid, unless the State Data Exchange (SDX) information indicates the SSI is terminated. The Worker must use appropriate procedures to provide Medicaid to the nursing facility client and the Essential Spouse.

24.13.2 DEEMED SSI RECIPIENTS

Deemed SSI recipients can be Medicaid clients even though they do not receive SSI. When the Deemed SSI recipient enters a nursing facility and is eligible for payment for his care, his coverage group does not change.

24.14 MANAGEMENT OF THE PERSONAL NEEDS ALLOWANCE (PNA)

This section is not applicable to clients who are in a Modified Adjusted Gross Income (MAGI) or Qualified Medicare Beneficiary (QMB) eligibility category.

Each nursing care patient is entitled to an allowance to meet his personal expenses. Any amount accumulated in the patient's personal expense account is an available asset. Responsibilities for the management of this allowance are outlined in this section.

24.14.1 NURSING FACILITY RESPONSIBILITIES

Funds in the personal expense account must not be used by the nursing facility to meet costs of services covered by the Medicaid nursing care payment. Examples of services and items covered by the nursing care payment are listed below. In addition, the facility must:

- Not charge a resident for any item or service not requested by the resident, or his authorized representative;
- Not require a resident to request any item or service as a condition of admission or continued stay; and,
- Inform the resident or his authorized representative requesting an item or service for which a charge will be made that there will be a charge for the item, and the amount.

When a facility has responsibility for a patient's Personal Needs Allowance (PNA), individual records must be kept with documentation of all disbursements made. Patient funds must be held in a separate account and not co-mingled with facility funds. Misuse of the personal funds by the facility is considered a fraudulent practice and any misappropriated funds must be repaid.

Because funds accumulated in the personal expense account are an asset, the facility is required to notify residents when they are within $200 of the asset limit.

When the patient is discharged, any unused amount remaining in his personal expense account is refunded to him by the facility.

24.14.2 CHARGES NOT PERMITTED

Nursing facilities may not charge a resident for the following examples of items and services:

- Routine, required nursing services.
- Use of equipment routinely used in the patient's care.
- Specialized rehabilitative services such as, but not limited to, physical therapy, speech language pathology, and occupational therapy.
- Required dietary services.
- Required activities program.
- Room/bed maintenance services.
- Basic personal laundry, not including dry cleaning, mending, hand washing, or other specialty services.
- Medically related social services.
- Personal hygiene items and services. Residents can purchase their own personal hygiene items if they choose, but the facility is required to provide them when needed, without charge. Examples of personal hygiene items and services that must be provided free by the facility include, but are not limited to:
    - Hair hygiene supplies
    - Comb and brush
    - Bath soap
    - Disinfecting soaps or specialized cleansing agents when needed to treat special skin problems or to fight infection
    - Razors
    - Shaving cream
    - Toothbrush and toothpaste
    - Denture adhesive and cleaner
    - Dental floss
    - Moisturizing lotion
    - Tissues
    - Cotton balls and swabs
    - Deodorant
    - Incontinence supplies and care

- Sanitary napkins and related supplies
- Towels and washcloths
- Hospital gowns
- Over-the-counter drugs
- Hair and nail hygiene services, but not cosmetic services
- Bathing

24.14.3 CHARGES PERMITTED

The following lists examples of items and services that the nursing facility may charge to the resident's personal expense account:

- Television/radio for personal use, including cable hook-up fee
- Telephone
- Personal comfort items, including smoking materials, lotions, novelties. and confections
- Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare
- Personal clothing
- Personal reading matter
- Gifts purchased on behalf of a resident
- Flowers and plants
- Social events and entertainment offered outside the scope of the nursing facility’s activity program
- Non-covered special care services, such as privately hired nurses or aides
- Private room, except when therapeutically required, such as isolation for infection control
- Specially prepared or alternative food specially requested, but not medically necessary, instead of the food prepared by the facility

24.14.4 WORKER RESPONSIBILITIES

At redetermination, the Worker verifies the accumulated balance in the client’s personal expense account. When the personal expense account, by itself or in combination with other assets, exceeds the asset limit, the case is closed after 13 days’ advance notice.

24.15 BILLING PROCEDURES AND PAYMENT AMOUNTS

Payments are made to the nursing facility in accordance with daily rates established by the agency for each facility that has been approved for Medicaid participation. The Worker must refer all inquiries about billing matters to Provider Services and must not act as a liaison between the Bureau for Medical Services (BMS) or their contract agency and the facility. See Appendix E.

INTERMEDIATE CARE FACILITIES/INDIVIDUALS WITH INTELLECTUAL DISABILITIES

24.16 APPLICATION/REDETERMINATION

If the client is currently enrolled in, or eligible for, full-coverage Medicaid, he must still be assessed for medical eligibility. If found eligible, the client must be assessed to determine if he must contribute to his cost of care. These clients, including Supplemental Security Income (SSI) and Deemed SSI recipients, must complete the DFA-LTC-5 at application and annual redetermination for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) to evaluate any annuities, trusts, and/or other potential resources or transfers unless they meet any listed exceptions. See Section 24.1.

If the client is not eligible for full-coverage Medicaid, he may be eligible the ICF/IID group if he meets certain income and asset standards. These applicants, including Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLIMB), and Qualified Individual – 1 (QI-1) clients, must complete the full application process. See Section 24.7. If found eligible, the client must contribute toward his cost of care.

If the client is not otherwise eligible, eligibility as an SSI-Related Medicaid client must be explored.

The application/redetermination process is the same as SSI-Related Medicaid, with the following exceptions that govern time limits on processing the application:

- As a result of the Medley, et al. vs Lipscomb court order, the Department of Health and Human Resources (DHHR) is required to determine an individual's eligibility for ICF/IID level of care and placement in a ICF/IID facility within three working days of receiving a completed application. Presumptive eligibility is determined using a DFA-ICF/MR-1. The case management agency, in conjunction with the admission committee from the certified ICF/IID facility, is responsible for determining the initial financial eligibility. This presumptive eligibility period may not exceed 30 days. The completed DFA-ICF/MR-1 is considered the initial application.

- The DFA-ICF/MR-1 form must be date-stamped when received in the local office. The three-working-day time limit begins the day after the DCA-ICF/MR-1 is received.

When the DFA-ICF/MR-1 form is received, the local office Community Services Manager (CSM) is responsible for:

- Having the case entered and approved for presumptive eligibility in the eligibility system within this three-working-day time limit.

- Assigning the case to a Worker. The Worker issues a DFA-6 to the client or his authorized representative to obtain any verification required to determine ongoing eligibility after the 30-day presumptive eligibility period. The DFA-6 has a 10-day time limit with the exception of spenddown cases.
- Assuring that a decision regarding ongoing eligibility is made within the 30-day presumptive period, once the required verification is received.

All ICF/IID applicants, other than those already admitted to and living in a certified facility, must apply for admission to the ICF/IID facility.

- The staff at the ICF/IID facility may use the DFA-ICF/MR-1 to presumptively determine medical and financial eligibility. When this is done, the procedures discussed above are followed; or
- When the application for ICF/IID is made using the DFA-2 or DFA-MA-1, and, thus no presumptive decision is made by the case management agency ICF/IID admission committee, the application is processed using SSI-Related Medicaid processing time limits.

NOTE: When the applicant's eligibility for, or enrollment in, this program is pending, he must not be refused the right to apply for any or all Division of Family Assistance (DFA) programs.

Eligibility is redetermined once a year and no interview is required.

24.17 COMMON ELIGIBILITY REQUIREMENTS

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) uses the same common eligibility requirements as Supplemental Security Income (SSI)-Related Medicaid. See Chapter 2.

24.18 ELIGIBILITY DETERMINATION GROUPS

24.18.1 THE ASSISTANCE GROUP (AG)

The resident of the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) is the only person in the AG.

24.18.2 THE INCOME GROUP (IG)

Only the income of the ICF/IID client is counted.

24.18.3 THE NEEDS GROUP (NG)

Monthly gross countable income is compared to 300% of the Supplemental Security Income (SSI) payment level for a single individual.

24.18.4 CASE COMPOSITION

Only the resident of the ICF/IID is included in the case.

24.19 INCOME

24.19.1 ELIGIBILITY

The determination of countable income sources for Supplemental Security Income (SSI)-Related Medicaid is used for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) cases. See Chapter 4.

The individual must have gross countable income at or below 300% of the SSI payment level. When income exceeds this limit, the client may be determined eligible for a monthly spenddown to the Medically Needy Income Level (MNIL) and become eligible. See Section 24.7.2.D.

24.19.2 POST-ELIGIBILITY

When the client has income at or below 300% of the SSI payment level or is eligible for a spenddown to the MNIL level, the post-eligibility process is used to determine the client's contribution to his cost of care. See Section 24.7.

Residents of an ICF/IID also receive an additional deduction of up to $65, in addition to the $50 personal needs allowance, when they have earned income from supportive or competitive employment in a sheltered workshop.

24.20 ASSETS

The determination of countable assets for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) cases is determined in the same way as for Supplemental Security Income (SSI)-Related Medicaid. Assets are compared to the limit for a single individual. See Chapter 5.

Transfer of resources, transfer of resources penalties, and spousal asset assessment policies apply, see Section 24.8.

24.21 NOTIFICATION

Notification policy and process is the same as it is for nursing facility services, as described in Section 24.9.

24.22 CASE MAINTENANCE

24.22.1 FACILITY TRANSFER

When an Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) client moves from one facility to another, the Worker must change the address and vendor number in the eligibility system. When the new facility is in another county, the case record must be transferred as well.

When the client resides in more than one ICF/IID facility in the same calendar month, the Worker must determine the portion of the client's cost contribution that must be paid to each facility in accordance with Section 24.7. Because the ICF/IID rate varies based on the individual's medical assessment, a standard rate per facility is not posted on the Department of Health and Human Resources' (DHHR) Intranet site. The Worker must contact each facility for the individual's ICF/IID rate.

24.22.2 CHANGES IN INCOME

If a client's income increases to more than 300% of the Supplemental Security Income (SSI) payment level, he is ineligible and must be reevaluated for all other Medicaid coverage groups including SSI-Related/Monthly Spenddown. Appropriate client notification, including advance notice requirements and data system action, apply.

24.23 BENEFIT REPAYMENT

24.23.1 CLIENT REPAYMENT

When payment for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) services is made for a client who is ineligible for such payment, only eligible for a lower benefit, or ineligible for Medicaid, repayment is pursued as specified in Chapter 11.

24.23.2 PROVIDER FRAUD

When fraud on the part of an ICF/IID service provider, facility, or other Medicaid provider is suspected, the procedures in Chapter 11 are followed.

24.23.3 ESTATE RECOVERY

Estate recovery applies to ICF/IID cases. See Section 24.11.

24.24 ESTABLISHING MEDICAL NECESSITY

Medical necessity for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) care is determined by the Bureau for Medical Services (BMS) contracted agency based on information provided by the ICF/IID facility on BMS forms DD-1 through DD-5.

The ICF/IID must submit the medical eligibility certification to the BMS contracted agency within 90 days of the date of placement in the ICF/IID.

The case management agency, in conjunction with the admission committee of the certified ICF/IID facility, may determine that applicants meet medical necessity requirements for placement in an ICF/IID facility on a presumptive basis not to exceed 30 days.

The first half of the presumptive application form, DFA-ICF/MR-1, is the medical certification that the ICF/IID placement is the least restrictive and best placement for the applicant, and must be signed by a licensed psychologist or other Qualified Intellectual Disabilities Professional (QIDP) on the day the applicant is admitted to the ICF/IID facility.

For applicants presumptively approved, the facility sends one copy of the DFA-ICF/MR-1 to the attention of the Community Services Manager (CSM) in the county where the ICF/IID facility is located, and one copy, along with the psychological/medical/social treatment plan that is compiled on forms DD-1 through DD-5, to the BMS contacted agency.

At the time of the client's presumptive approval, the psychological/medical/social treatment plan is submitted to the BMS contracted agency to document that the client meets medical necessity criteria. When the BMS contracted agency makes a determination, the CSM is notified. The effective date of a finding of medical necessity is indicated in the memorandum.

24.25 SPECIAL ELIGIBILITY SYSTEM INSTRUCTIONS

Supplemental Security Income (SSI) recipients and Deemed SSI recipients who participate in intermediate care facilities for individuals with intellectual disabilities (ICF/IID) are coded in the eligibility system. SSI and Deemed SSI recipients remain in the same category while also being dually coded as ICF/IID clients.

24.26 MANAGEMENT OF THE PERSONAL NEEDS ALLOWANCE

See Section 24.14.

24.27 BILLING PROCEDURES AND PAYMENT AMOUNTS

Payment to the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) is the responsibility of the Bureau for Medical Services (BMS) and its contract agency. The BMS contract agency maintains a Provider Services helpline for vendor questions. See Appendix E.

COMMON WAIVER INFORMATION FOR AGED AND DISABLED WAIVER (ADW), INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD) WAIVER, AND TRAUMATIC BRAIN INJURY WAIVER (TBI)

24.28 COMMON ELIGIBILITY REQUIREMENTS

Waiver coverage groups use the same common eligibility requirements as Supplemental Security Income (SSI)-Related Medicaid. See Chapter 2.

24.29 ELIGIBILITY DETERMINATION GROUPS

24.29.1 THE ASSISTANCE GROUP (AG)

The waiver client is the only person in the AG.

24.29.2 THE INCOME GROUP (IG)

Only the income of the waiver client is counted. No income eligibility determination is required for Supplemental Security Income (SSI) and Deemed SSI recipients. Income is not deemed.

24.29.3 THE NEEDS GROUP (NG)

Gross countable income is compared to 300% of the SSI payment level for a single individual. No needs test is applied to SSI and Deemed SSI Medicaid clients.

24.29.4 CASE COMPOSITION

Only the waiver client is the primary person in the case, unless he is an SSI recipient with an Essential Spouse. See Section 23.11.

24.30 INCOME

Only the income of the waiver client is to be counted. No income is deemed to the client.

The determination of which income sources to count is the same as Supplemental Security Income (SSI)-Related Medicaid. See Chapter 4.

The client's monthly gross countable income must be equal to or less than 300% of the maximum SSI payment for a single individual.

There is no post-eligibility process for this coverage group.

24.31 ASSETS

The determination of countable asset sources is the same as for Supplemental Security Income (SSI)-Related Medicaid. See Chapter 5. The SSI-Related Medicaid asset limit for one person is used. Assets are not deemed for clients of waiver services.

SSI and Deemed SSI Medicaid coverage groups have no additional asset test at application for waiver services however must be evaluated for transfer resources, trust and annuities.

For transfers of resources, see Section 24.8. See Section 24.8 for the spousal assessment of assets. Both apply to Aged and Disabled (ADW), Intellectual and Developmental Disabilities (I/DD), and Traumatic Brain Injury (TBI) waiver services.

24.31.1 TRANSFER OF RESOURCES PENALTY FOR AN APPLICANT

A penalty does not start for a waiver applicant until he is actually a recipient of an institutional level of care or nursing facility level of care that Medicaid would pay for, were it not for imposition of the transfer penalty. The penalty does not begin for the waiver applicant unless he enters a nursing facility or other facility providing an institutional level of care. He cannot become Medicaid eligible for waiver services due to the penalty, and the penalty period cannot begin until Medicaid would begin paying for waiver services.

24.31.1.A Applicant Asset Transfer Examples

> **Applicant Asset Transfer Example 1:** Ms. Freesia, a 70-year-old woman, applies for ADW services in July 2016 but transferred cash from her bank account to her daughter in January 2014. Ms. Freesia is subject to a transfer of resources penalty for 15.4 months. Her health deteriorates, and she is admitted to a nursing facility in September 2016 for several months. Ms. Freesia cannot receive payment for ADW services from July through September 2016 due to the transfer of resources. Her penalty period cannot begin until she goes into the nursing home. Her penalty period begins in September 2016 and she will be eligible for ADW services in August 2017, if otherwise eligible, with a partial month penalty in September 2017. Ms. Freesia will be eligible in September whether or not she receives long term care services for the entire penalty period as long as she was institutionalized at the start of the penalty period.

> **Applicant Asset Transfer Example 2:** Mr. Orchid, a 67-year-old man, applies for TBI waiver services in August 2016, but transferred cash from his bank account to his son in February 2017. Mr. Orchid is subject to a seven-month penalty. He never begins receiving waiver services because Medicaid never begins payment for these services due to the penalty. Mr. Orchid never entered a nursing home or equivalent institutional level of care, so the penalty period never began.

24.31.2 TRANSFER OF RESOURCES PENALTY FOR A CLIENT

When a waiver services client transfers resources without receiving fair compensation, a penalty is applied after advance notice. The penalty period is determined using the following procedure and lasts for the number of whole and/or partial months determined by the following calculation.

The total amount transferred during the look-back period is divided by the State's average monthly nursing facility private pay rate of $331 per day, or $9,930 per month.

When the remaining amount of the transfer is less than the average monthly private pay cost of nursing facility care, the agency imposes a penalty for less than a full month. The partial month's penalty is converted to a number of days for which the individual is ineligible for payment for waiver services.

The partial month's penalty is determined as follows:

Step 1: The total amount transferred is divided by the State's average monthly nursing facility private pay rate of $9,930.

Step 2: Multiply the number of whole months from Step 1 by the average private pay rate of $9,930.

Step 3: Subtract the amount in Step 2 from the total amount of all transfers. The remainder is the amount used to determine the number of days the individual is ineligible for waiver services in the partial month of the penalty period.

Step 4: The Step 3 amount is divided by the average daily rate of $331 to determine the number of days of ineligibility in the last month of the penalty period.

24.31.2.A Client Asset Transfer Examples

Client Asset Transfer Example 1: Mr. Alder makes an uncompensated transfer of $24,534 after approval for ADW services and Medicaid.

Step 1:	$24,534	Uncompensated transfer amount
	÷$9,930	State's average monthly nursing facility pay rate
	2.47	Number of months for penalty period
Step 2:	$9,930	State's average monthly nursing facility private pay rate
	x 2	Whole months in penalty period
	$19,860	
Step 3:	$24,534	Total uncompensated transfer amount
	-$19,860	Amount for three whole months in penalty period
	$4,674	Partial month penalty amount62
Step 4:	$4,674	
	÷ $331	Average daily rate
	14.12	Number of ineligible days for partial month

The partial penalty is imposed for the number of whole days only. If an ADW client transfers resources in July and advance notice is provided for August closure, the penalty period runs for two full months from August through September, with a partial month penalty of 14 days calculated for October. The individual becomes eligible for ADW on October 15 if he meets all other requirements.

Client Transfer Example 2: Ms. Ivy is receiving TBI services and transfers her home to her daughter without compensation in October 2019. The value of the home is $100,000. After advance notice, the penalty period is October 2019 through July 2020 for 10 whole months. A partial month penalty is calculated for August 2020, the 11th month, based on $700 remaining of the total penalty amount. $700 ÷ $331 = 2.11 days of ineligibility in August 2020. Any fractional days are dropped and the length of the penalty is based on the number of whole days. If otherwise eligible, payment for TBI services is approved effective August 3, 2020.

Client Transfer Example 3: Mr. Juniper enters a nursing facility in October 2016 and applies for long term care services. He has a transfer penalty of 1.17

months. The whole month penalty is applied for October 2016 and the partial month penalty is added to his November 2016 contribution for his cost of care. He is approved for ADW services and will return to his home on November 1, 2016. The partial month penalty is recalculated into days for November 2016.

24.32 BENEFIT REPAYMENT

24.32.1 CLIENT REPAYMENT

When payment for waiver services is made for a client who is ineligible for such payment, or for Medicaid, repayment is pursued as specified in Chapter 11.

24.32.2 PROVIDER FRAUD

When fraud on the part of the waiver service provider, facility, case management agency, or other Medicaid provider is suspected, the procedures in Chapter 11 are followed.

24.32.3 ESTATE RECOVERY

Estate recovery liens apply to Aged and Disabled Waiver (ADW) clients, Traumatic Brain Injury (TBI) waiver clients, and nursing facility clients. See Section 24.11. Refer all questions to the contract agency for Estate Recovery. Information about this agency is found in Appendix E.

Estate recovery does not apply to Intellectual and Developmental Disability (I/DD) waiver cases, unless the I/DD client is age 55 or over and enters an institution.

24.33 SPECIAL ELIGIBILITY SYSTEM INSTRUCTIONS

24.33.1 CURRENT SSI AND DEEMED SSI RECIPIENTS

Supplemental Security Income (SSI) and Deemed SSI recipients receiving waiver services remain in the same SSI and Deemed SSI category in the eligibility system. SSI and Deemed SSI recipients are not dually coded.

24.33.2 ALL OTHERS

Clients eligible for waiver services who do not receive SSI or Deemed SSI are coded in the appropriate waiver category in the eligibility system.

24.34 MANAGEMENT OF THE PERSONAL NEEDS ALLOWANCE

The personal needs allowance does not apply to waiver services.

24.35 BILLING PROCEDURES AND PAYMENT AMOUNTS

Payment to the case management agencies is the responsibility of the Bureau for Medical Services (BMS) and its contract agency. The BMS contract agency maintains a Provider Services helpline for vendor questions. All inquiries from case management agencies, service providers, or vendors about billing must be referred to Provider Services. See Appendix E.

24.36 TAKE ME HOME TRANSITION PROGRAM

The Take Me Home (TMH) Transition Program is a program of the West Virginia Bureau for Medical Services (BMS). The purpose of TMH is to identify qualifying residents of long-term care facilities who wish to return to their own homes and apartments in the community and provide them the supports and services they need to do so. Nursing Home residents wanting to return to the community with Take Me Home support, must be determined financially and medically eligible for either the Aged and Disabled Waiver (ADW) or the Traumatic Brain Injury Waiver (TBIW) program.

The West Virginia Department of Health and Human Resources (DHHR) Referral Form for the Medicaid ADW or TBIW Program (DHS-2.FRM) is submitted to the Worker to begin the financial eligibility determination process as outlined in this manual beginning in section 24.37.3. The DHS-2 form has two versions, one yellow and one white. The yellow DHS-2 form is required for initial financial eligibility determination and must be presented to the Worker to begin the initial financial eligibility determination process. Please note that a projected date of discharge is not required or needed to process the yellow DHS2 form for TMH clients.

The following procedure needs to be applied when processing the white DHS-2 form for a TMH client that has a probable transition date from a nursing facility to the community. The Waiver Case Management Provider or the Bureau of Senior Services (BoSS), or the Utilization Manager (UMC) must contact the Department of Health and Human Resources (DHHR) for an ADW or TBIW financial eligibility determination of a Take Me Home client. The Waiver Case Management Provider, BoSS, or the UMC must send the white DHS-2 form within two business weeks of the client's projected date of discharge. The Worker must evaluate the client's financial eligibility based on the current information in the case record. If financially eligible, the Worker completes the white DHS-2 form. The effective date for the white DHS-2 form is the projected date of discharge. Once the form is complete, the Worker submits the white DHS-2 form to the appropriate agency indicating the client's financial eligibility. This may be submitted by fax, scan, or mail.

The Worker records the action taken in the case record. The completed white DHS-2 form is valid for 30 days after the effective/projected date of discharge. When the white DHS-2.FRM expires, the entire white DHS-2 form process is void and the procedure is repeated as needed.

The Nursing Facility or Case Management Provider will contact the DHHR Worker when the actual discharge occurs. The Worker updates the eligibility system with the actual discharge date, evaluates financial eligibility to complete the procedure, and again comments that the action was taken.

Information about the Take Me Home Transition Program is found on the BMS website or by calling 1-855-519-7557

~~Take Me Home, West Virginia assists individuals residing in long term care facilities transition home or into the community while retaining long term care and support services.~~

~~The following procedure needs to be applied when there is a probable transition from a nursing facility to the home or community. The Waiver Case Management Provider, the Bureau of Senior Services (BoSS), or the Utilization Manager (UMC) must contact the Department of Health and Human Resources (DHHR) for an Aged and Disabled Waiver (ADW) or Traumatic Brain Injury (TBI) Waiver financial eligibility determination of a Take Me Home, West Virginia client.~~

~~The Waiver Case Management Provider, BoSS, or the UMC must send the DHHR a DHS-2 form within two business weeks of the client's projected date of discharge. The Worker must evaluate the client's financial eligibility based on the current information in the case record. If financially eligible, the Worker completes the DHS-2 with the effective (projected discharge) date and submits the DHS-2 to the appropriate agency indicating the client's financial eligibility. This may be submitted by fax, scan, or mail.~~

~~The Worker records the action taken in the case record. The completed Take Me Home, West Virginia DHS-2 is valid for 30 days after the effective date of discharge. When the DHS-2 expires, the entire process is void and the procedure is repeated as needed.~~

~~The nursing facility will contact the DHHR when the actual discharge occurs. The Worker updates the eligibility system with the actual discharge date, evaluates financial eligibility to complete the procedure, and again comments the action taken.~~

~~Information about waiver services, such as self-directed and personal options, is found on the BoSS website. A listing of case management agencies by county is also found on this site.~~

AGED AND DISABLED WAIVER (ADW)

24.37 APPLICATION/REDETERMINATION

The West Virginia Department of Health and Human Resources (DHHR) Referral Form for Medicaid Aged and Disabled Waiver (ADW) Program, Initiate Financial Eligibility (DHS-2.FRM) must be presented to begin the ADW financial eligibility determination process.

The DHS-2.FRM form has two versions, one yellow and one white.

- The yellow DHS-2.FRM instructs the Worker to determine financial eligibility. Financial eligibility is determined for the ADW program before medical eligibility is initiated.
- The white DHS-2.FRM, along with the Notice of Decision letter, confirms the client is medically-eligible and that a funded waiver slot is available for the ADW program.

The steps in the application process are outlined in below.

24.37.1 GENERAL APPLICATION PROCEDURES

24.37.1.A Application Forms

New applicants must apply for ADW Medicaid using the DFA-MA-1, DFA-2, or DFA-SLA-1 and DFA-SLA-S1. Current Supplemental Security Income (SSI) and Deemed SSI Medicaid clients must complete the DFA-LTC-5 form to evaluate for trusts, transfers, and annuities.

An interview is not required. If a face-to-face interview is requested by the client or their authorized representative, the appointment must be scheduled within 10 calendar days of the date of the contact. The appointment may be scheduled after 10 calendar days only at the request of the client or his authorized representative.

24.37.1.B Complete Application

The application is complete when the client or his authorized representative signs the appropriate application form which contains, at a minimum, the client's name, address, and signature.

24.37.1.C Date of Application

The date of application is the date the applicant submits an appropriate application form in person, by electronic transmission or by mail, which contains, at a minimum, his name, address, and signature. When the application is submitted by mail or electronically, the date of application is the date that the form with the name, address, and signature is received in the local office.

24.37.1.D Who Must Sign

The application must be signed by the applicant, the spouse or the authorized representative. See Section 24.4 for more information on authorized representatives.

24.37.1.E Due Date of Additional Information

Additional information is due 30 days from the date of application.

24.37.1.F Application Processing Limits

Eligibility system action to approve, deny or withdraw the application must be taken within 30 days of the date of application.

24.37.1.G Beginning Date of Eligibility

The beginning date of Medicaid eligibility is:

- The first day of the month that the client is financially eligible and the Worker receives notice that the client is medically-eligible and awarded a funded slot for waiver services; or
- The first day of the month in which the individual is eligible for payment of ADW services after a transfer of resources penalty expires. See Section 24.29.

24.37.1.H The Benefit

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

ADW services will only be paid on or after the ADW approval date.

24.37.2 STEPS IN THE APPLICATION PROCESS

Steps in the application process are as follows.

24.37.2.A Step One: Receipt of the DHHR Referral Form for Medicaid Aged and Disabled Waiver Program, Initiate Financial Eligibility (DHS-2.FRM) YELLOW FORM

The yellow DHS-2.FRM will originate from the ADW Utilization Management Contractor (UMC). The current UMC contact information is found in Appendix E.

The yellow DHS-2.FRM may be submitted by the client or a case management agency and instructs the worker to determine financial eligibility. The client must also submit an appropriate Medicaid application form. General application procedures above must be followed.

24.37.2.A.1 Expired Yellow DHS-2.FRM

If the yellow DHS-2.FRM is expired, the Worker checks the box indicating it is expired and faxes the form back to the ADW UMC.

24.37.2.A.2 Yellow DHS-2.FRM with Missing Expiration Date

If there is no expiration date on the yellow DHS-2.FRM, it should be faxed back to the UMC, noting there is no expiration date.

24.37.2.A.3 Current (Not Expired) Yellow DHS-2.FRM

If the yellow DHS-2.FRM is not expired:

- The Worker completes the financial eligibility determination following the general application procedures above. A Medicaid application must be received by the Worker prior to the DHS-2.FRM expiration date. However, the application process does not have to be completed prior to the expiration date.
- If the client does not submit an appropriate Medicaid application form with the yellow DHS-2.FRM, the Worker must send an application to the client.
- If the client does not submit the appropriate Medicaid application form prior to the yellow DHS-2.FRM expiration date, the Worker checks the box indicating the application was not completed and faxes the form back to the UMC.

24.37.2.A.4 Client Is Determined Financially Eligible

If the client is determined financially eligible for the ADW:

- The Worker confirms the pending ADW category. Financial eligibility for the ADW category is pended up to 90 days in the data system awaiting verification of medical eligibility and availability of a funded ADW slot. The client is notified by a system generated letter.
- The Worker checks the box on the yellow DHS-2.FRM indicating the client is financially eligible and faxes the form back to the UMC. This will initiate medical eligibility to be determined by the UMC.

24.37.2.A.5 Client Is Determined Financially Ineligible

If the client is determined financially ineligible for the ADW:

- The Worker checks the box on the yellow DHS-2.FRM indicating the client is ineligible and faxes the form back to the UMC.
- The Worker then evaluates for all other Division of Family Assistance (DFA) programs. The client will be sent a denial letter by the eligibility system.

24.37.2.B Step Two: Receipt of the DHHR Referral Form for Medicaid Aged and Disabled Waiver Program (DHS-2.FRM) WHITE FORM

The white DHS-2.FRM, along with the Notice of Decision letter, confirms to the Worker the client was determined medically-eligible and awarded a funded slot for the ADW program.

The white DHS-2.FRM originates from a case management agency if the client chooses the traditional service delivery model, or from the Bureau of Senior Services (BoSS) if the client chooses the personal options delivery model.

24.37.2.B.1 Expired White DHS-2.FRM

If the white DHS-2.FRM form is expired, the Worker checks the box indicating it is expired and faxes the form back to the originating agency. Medicaid is not approved.

24.37.2.B.2 White DHS-2.FRM with Missing Expiration Date

If there is no expiration date on the white DHS-2.FRM, it should be faxed back to the originating agency, noting there is no expiration date. Medicaid is not approved.

24.37.2.B.3 Current (Not Expired) White DHS-2.FRM

If the white DHS-2.FRM is not expired:

- The Worker updates financial eligibility.

- If ADW financial eligibility was determined in the last 90 days and is in pending status, the Worker updates the system and approves Medicaid ADW program eligibility.
- If more than 90 days have passed since financial eligibility was determined, the client must be reevaluated for financial eligibility. Medicaid ADW is not approved. The client must submit a new application prior to the expiration date on the white form.

- The Worker checks the appropriate box on the white DHS-2.FRM indicating whether the client is eligible or ineligible for Medicaid ADW and faxes the form back to the originating agency.
- The client has only 60 days after acquiring a waiver slot to establish eligibility and be enrolled in the waiver program, or they will lose their slot. Timely financial eligibility determinations are critical.

NOTE: When the applicant's eligibility for or enrollment in this program is pending due to the lack of a waiver slot or other reason, he must not be refused the right to apply due to his pending status for the ADW group, but must be evaluated for any or all DFA programs.

> **ADW Application Example:** Mr. Beech applies for ADW, which requires a medical eligibility decision by the ADW program and a financial determination by an Income Maintenance Worker. While his medical eligibility decision is pending, he visits his local DHHR office and applies for the Supplemental Nutrition Assistance Program (SNAP). Although his medical eligibility for ADW has not been determined and a financial determination cannot be made by the Worker for ADW, his pending status for this program does not prevent his evaluation for all other Medicaid groups or DFA programs for which he may qualify.

24.37.3 WAIVER APPLICANTS CURRENTLY RECEIVING MEDICAID PAYMENT FOR NURSING FACILITY SERVICES

For ADW applicants currently receiving Medicaid payment for nursing facility services, the following steps are used.

24.37.3.A Step One: Receipt of the DHHR Referral Form for Medicaid Aged and Disabled Waiver Program, Initiate Financial Eligibility (DHS-2.FRM) YELLOW FORM

The yellow DHS-2.FRM instructs the Worker to determine financial eligibility. The Worker must first evaluate the client's financial eligibility based on the current information in the case record.

Clients currently receiving Medicaid payment for nursing facility services in the Nursing Facility coverage group, or as an SSI or Deemed SSI recipient, have been determined financially eligible and are not required to complete a new Medicaid application upon receipt of the yellow DHS-2.FRM.

All other clients currently receiving Medicaid payment for nursing facility services must submit an appropriate waiver application form prior to the expiration date on the yellow DHS-2.FRM.

24.37.3.A.1 Expired Yellow DHS-2.FRM

If the yellow DHS-2.FRM is expired, the Worker checks the box indicating it is expired and faxes the form back to the ADW UMC.

24.37.3.A.2 Yellow DHS-2.FRM with Missing Expiration Date

If there is no expiration date on the yellow DHS-2.FRM, it should be faxed back to the UMC, noting there is no expiration date.

24.37.3.A.3 Current (Not Expired) Yellow DHS-2.FRM

If the yellow DHS-2.FRM is not expired:

- If the client is currently receiving Medicaid in the Nursing Facility, SSI or Deemed SSI coverage group, the Worker checks the box on the yellow DHS-2.FRM indicating the client is financially eligible and faxes the form back to the UMC. This will initiate medical eligibility to be determined by the UMC.
- If not currently financially eligible, the Worker completes the financial eligibility determination following the general application procedures above. A Medicaid application must be received by the Worker prior to the DHS-2.FRM expiration date, if applicable. However, the application process does not have to be completed prior to the expiration date.
- If the client does not submit an appropriate Medicaid application form with the yellow DHS-2.FRM, the Worker must send an application to the client.

- If the client does not submit the appropriate Medicaid application form prior to the yellow DHS-2.FRM expiration date, the Worker checks the box indicating the application was not completed and faxes the form back to the UMC.

24.37.3.B Step Two: Receipt of the DHHR Referral Form for Medicaid Aged and Disabled Waiver Program (DHS-2.FRM) WHITE FORM

The white DHS-2.FRM, along with the Notice of Decision letter, confirms to the Worker the client was determined medically-eligible and awarded a funded slot for the ADW program.

24.37.3.B.1 Expired White DHS-2.FRM

If the white DHS-2.FRM form is expired, the Worker checks the box indicating it is expired and faxes the form back to the originating agency. Medicaid coverage for nursing facility services continues if all requirements are met.

24.37.3.B.2 White DHS-2.FRM with Missing Expiration Date

If there is no expiration date on the white DHS-2.FRM, it should be faxed back to the originating agency, noting there is no expiration date. Medicaid coverage for nursing facility services continues if all requirements are met.

24.37.3.B.3 Current (Not Expired) White DHS-2.FRM

If the white DHS-2.FRM is not expired:

- The Worker approves eligibility in the ADW category upon notification the client has been discharged from the nursing facility.
- The Worker checks the appropriate box on the white DHS-2.FRM indicating whether the client is eligible or ineligible for Medicaid ADW and faxes the form back to the originating agency.

The client has only 60 days after acquiring a waiver slot to establish eligibility and be enrolled in the waiver program, or they will lose their slot. Timely financial eligibility determinations are critical.

24.37.4 REDETERMINATION PROCESS

A redetermination of eligibility is completed once a year; a face-to-face interview is not required. The Worker receives an alert in the eligibility system when a redetermination is due. The Worker must manually set an alert to schedule the redetermination for SSI and Deemed SSI waiver clients.

The same financial criteria used at application applies at each annual redetermination. Medical necessity must be verified annually at redetermination with a Notice of Decision letter or document from the UMC stating the client continues to be eligible. If the client continues to meet financial and medical requirements, Medicaid eligibility for waiver services is established. Continued medical eligibility for services is monitored by the Bureau for Medical Services (BMS).

24.38 NOTIFICATION

24.38.1 CLIENT

Notification procedures in Chapter 9 are applicable.

24.38.2 CASE MANAGEMENT AGENCY (CMA) OR THE BUREAU OF SENIOR SERVICES (BoSS)

At application, the Worker sends a copy of the completed white DHS-2.FRM to the originating agency within 30 days of completion of the application. This notifies the CMA of the financial eligibility decision and provides them with the Medicaid ID. The Worker retains a copy of the completed DHS-2.FRM for the case record.

The Worker must also notify the CMA, or the BoSS if the client is a Personal Options member, when an Aged and Disabled Waiver (ADW) client becomes ineligible for any reason, using the original form DHS-2.FRM, a DHS-1, or a free-format letter.

24.39 CASE MAINTENANCE

24.39.1 COUNTY TRANSFER

When an Aged and Disabled Waiver (ADW) client moves from one county to another, the case record must be transferred to the new county of residence.

24.39.2 CHANGES IN INCOME FOR THE ADW COVERAGE GROUP

When the client's income increases to above 300% of the Supplemental Security Income (SSI) payment level, he is no longer eligible for ADW services. The Worker must:

- Notify the case management agency or the West Virginia Bureau of Senior Services (BoSS)
- Notify the client or his authorized representative by providing 13 days' advance notice
- Update the eligibility system
- Evaluate the client for all other Medicaid coverage groups

24.39.3 CHANGE IN MEDICAL CONDITION

When the client's medical condition improves to the extent that ADW services are no longer required, he is ineligible for the ADW coverage group. If this is the method by which he qualified for Medicaid, he must be evaluated for all other Medicaid coverage groups. ADW services are no longer paid under Medicaid.

If the ADW client's condition changes to the extent that care in a nursing facility is required, the following conditions must be met before Medicaid can pay for nursing facility services:

- A valid pre-admission screening (PAS) was completed on the date the client entered the nursing facility or within the 60-day period prior to entering the facility.
- The post-eligibility process to determine the client's contribution to his cost of care was completed. See Section 24.7.3 for instructions.
- All notification procedures outlined in Section 24.9 were followed.

- The redetermination cycle remains the same for the assistance group (AG). When this change occurs in the month of redetermination, it must be completed at the same time as the change from ADW to nursing facility services.
- When the individual is under age 65, not blind, and does not receive a disability benefit or meet any other criteria specified in Section 13.4, disability must be established by the Medical Review Team (MRT). See Section 24.12.1.

24.40 ESTABLISHING MEDICAL NECESSITY

Medical necessity is determined by the Bureau for Medical Services (BMS) Utilization Management Contracted agency (UMC). When the UMC sends the white DHS-2.FRM, along with the Notice of Decision letter, medical necessity is presumed to be determined.

The Worker has responsibility in this process to obtain the letter from the UMC as verification of medical eligibility at application and redetermination. The BMS, UMC, or case manager notifies the Worker when a client no longer meets medical necessity criteria for Aged and Disabled Waiver services.

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD)

24.41 APPLICATION/REDETERMINATION PROCESS – I/DD

The application process for financial eligibility for Intellectual and Developmental Disabilities (I/DD) Waiver begins when the Worker receives a memorandum from the Bureau for Medical Services (BMS) contract agency listed in Appendix E. The memorandum (Notice of Decision Letter for medical eligibility) gives the date that medical necessity for I/DD Waiver services eligibility is established and verifies a funded slot is available.

24.41.1 GENERAL APPLICATION PROCEDURES

24.41.1.A Application Forms

Current clients of Supplemental Security Income (SSI), Deemed SSI, Parent/Caretaker Relatives, Children under Age 19, and Pregnant Women must complete only the DFA-LTC-5 to evaluate for annuities, trusts, and/or other potential resources or transfers when determined medically-eligible for I/DD.

All other new applicants must apply for I/DD waiver Medicaid using the DFA-MA-1, DFA-2, or DFA-SLA-1 and DFA-SLA-S1.

24.41.1.B Complete Application

The application is complete when the client or his representative signs the appropriate application form which contains, at a minimum, the client's name, address, and signature. An interview is not required.

24.41.1.C Date of Application

The date of application is the date the applicant submits an appropriate application form in person, by electronic transmission or by mail, which contains, at a minimum, his name, address,

and signature. When the application is submitted by mail or electronically, the date of application is the date that the form with the name, address, and signature is received in the local office.

24.41.1.D Who Must Sign

The application must be signed by the applicant, the spouse, or the authorized representative. See Section 24.4 for more information on authorized representatives.

When the applicant is a child under age 18, the parent(s) or legal guardian must sign.

24.41.1.E Due Date of Additional Information

Additional information is due 30 days from the date of application.

24.41.1.F Application Processing Limits

Data system action to approve, deny, or withdraw the application must be taken within 30 days of the date of application.

24.41.1.G Beginning Date of Eligibility

The beginning date of Medicaid eligibility is the later of the following:

- The date of initial medical eligibility which is established by the BMS contract agency; or
- The date on which the applicant was approved for financial eligibility.

24.41.1.H The Benefit

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid

approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

I/DD waiver services will only be paid on or after the I/DD waiver approval date.

NOTE: When the applicant's eligibility for or enrollment in this program is pending he must not be refused the right to apply due to his pending status for the I/DD group, but must be evaluated for any or all Division of Family Assistance (DFA) programs.

24.41.2 REDETERMINATION PROCESS

I/DD cases are redetermined financially once a year. An interview is not required. The same financial criteria used at application applies at each annual redetermination.

The Worker receives an alert in the eligibility system when a redetermination is due. The Worker must manually schedule the redetermination for SSI and Deemed SSI I/DD waiver clients. SSI and Deemed SSI clients must complete the DFA-LTC-5 to complete an I/DD waiver redetermination.

Medical necessity must be verified annually at redetermination with a letter from the Utilization Management Contractor (UMC) stating the client continues to be eligible. If the client continues to meet financial and medical requirements, Medicaid eligibility for waiver services is established. Continued medical eligibility for services is monitored by the BMS.

Medicaid is continued when the case is in hearing status or an extension has been granted by the Office of I/DD Waiver Services in the BMS due to circumstances beyond the individual's control.

Information about I/DD Waiver Services is found on the BMS website on the Office of Home and Community Based Services page. The I/DD Waiver application (WV-BMS-IDD-01) needed to determine medical eligibility can be found on the BMS website and on the DFA intranet forms page.

24.42 NOTIFICATION

24.42.1 CLIENT

Notification procedures in Chapter 9 are applicable.

24.42.2 CASE MANAGEMENT AGENCY (CMA)

The Worker notifies the CMA when:

- The client's financial determination is made or the client's receipt of Supplemental Security Income (SSI);
- The Intellectual and Developmental Disability (I/DD) Waiver case is approved and the date the client is eligible for services;
- The I/DD client becomes ineligible for any reason.

The case manager notifies the Worker when:

- An application is required;
- The client no longer requires I/DD waiver services.

24.42.3 OTHER

The Bureau for Medical Services (BMS) contract agency notifies the Community Services Manager (CSM) when the client's medical necessity for I/DD waiver services is established.

24.43 CASE MAINTENANCE

24.43.1 COUNTY TRANSFER

When an Intellectual and Developmental Disability (I/DD) waiver client moves from one county to another, the case record must be transferred to the new county of residence.

24.43.2 CHANGES IN INCOME

When the client's income increases to above 300% of the Supplemental Security Income (SSI) payment level, he is no longer eligible for I/DD waiver services.

The Worker must:

- Notify the Bureau for Medical Services (BMS) for the ending date of eligibility for I/DD;
- Notify the client or his authorized representative by providing 13 days' advance notice;
- Notify the case management agency;
- Update the eligibility system; and,
- Evaluate the client for all other Medicaid coverage groups.

24.43.3 CLOSURE/DENIAL

When an I/DD case is closed or denied and an application is taken for nursing facility services, no waiver services are covered under Medicaid.

24.44 ESTABLISHING MEDICAL NECESSITY

The Bureau for Medical Services (BMS) contract agency determines medical necessity for Intellectual and Developmental Disability (I/DD) waiver services.

The BMS contract agency notifies the Community Services Manager (CSM) by memorandum of the Notice of Decision, client's name, and the date that medical necessity for I/DD waiver services was established.

Medicaid is continued when the case is in hearing status or an extension has been granted by the Office of I/DD waiver services in the BMS due to circumstances beyond the client’s control.

TRAUMATIC BRAIN INJURY (TBI) WAIVER

24.45 APPLICATION/REDETERMINATION

The West Virginia Department of Health and Human Resources (DHHR) Referral Form for Medicaid Traumatic Brain Injury (TBI) Waiver Program, Initiate Financial Eligibility (DHS-2.FRM) must be presented to begin the TBI waiver financial eligibility determination process.

The DHS-2.FRM form has two versions, one yellow and one white.

- The yellow DHS-2.FRM instructs the Worker to determine financial eligibility. Financial eligibility is determined for the TBI waiver program before medical eligibility is initiated.
- The white DHS-2.FRM, along with the Notice of Decision letter, confirms the client is medically-eligible and that a funded waiver slot is available for the TBI waiver program.

The steps in the application process are outlined in Section 24.45.2 below.

24.45.1 GENERAL APPLICATION PROCEDURES

24.45.1.A Application Forms

New applicants must apply for TBI waiver Medicaid using the DFA-MA-1, DFA-2, or DFA-SLA-1 and DFA-SLA-S1. Current Supplemental Security Income (SSI) and Deemed SSI clients must complete the DFA-LTC-5 form to evaluate for trusts, transfers, and annuities.

An interview is not required. If a face-to-face interview is requested by the client or their authorized representative, the appointment must be scheduled within 10 calendar days of the date of the contact. The appointment may be scheduled after 10 calendar days only at the request of the client or his authorized representative.

24.45.1.B Complete Application

The application is complete when the client or his authorized representative signs the appropriate application form which contains, at a minimum, the client's name, address and signature.

24.45.1.C Date of Application

The date of application is the date the applicant submits an appropriate application form in person, by electronic transmission or by mail, which contains, at a minimum, his name, address and signature. When the application is submitted by mail or electronically, the date of application is the date that the form with the name, address, and signature is received in the local office.

24.45.1.D Who Must Sign

The application must be signed by the applicant, the spouse, or the authorized representative. See Section 24.4 for more information on authorized representatives. When the applicant is a child under age 18, the parent(s) or legal guardian must sign.

24.45.1.E Due Date of Additional Information

Additional information is due 30 days from the date of application.

24.45.1.F Application Processing Limits

Eligibility system action to approve, deny, or withdraw the application must be taken within 30 days of the date of application.

24.45.1.G Beginning Date of Eligibility

The beginning date of Medicaid eligibility is:

- The first day of the month that the client is financially eligible and the Worker receives notice that the client is medically-eligible and awarded a funded slot for waiver services; or

- The first day of the month in which the individual is eligible for payment of TBI waiver services after a transfer of resources penalty expires. See Section 24.31.

24.45.1.H The Benefit

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

TBI waiver services will only be paid on or after the TBI waiver approval date.

24.45.2 STEPS IN THE APPLICATION PROCESS

Steps in the application are as follows.

24.45.2.A Step One: Receipt of the DHHR Referral Form for Medicaid Traumatic Brain Injury Waiver Program, Initiate Financial Eligibility (DHS-2.FRM) YELLOW FORM

For Step One of the application process, the yellow DHS-2.FRM will originate from the TBI waiver Utilization Management Contractor (UMC). The current UMC contact information is found in Appendix E.

The yellow DHS-2.FRM may be submitted by the client or a case management agency and instructs the worker to determine financial eligibility. The client must also submit an appropriate Medicaid application form. General application procedures above must be followed.

24.45.2.A.1 Expired Yellow DHS-2.FRM

If the yellow DHS-2.FRM is expired, the Worker checks the box indicating it is expired and faxes the form back to the TBI waiver UMC.

24.45.2.A.2 Yellow DHS-2.FRM with Missing Expiration Date

If there is no expiration date on the yellow DHS-2.FRM, it should be faxed back to the UMC, noting there is no expiration date.

24.45.2.A.3 Current (Not Expired) Yellow DHS-2.FRM

If the yellow DHS-2.FRM is not expired:

- The Worker completes the financial eligibility determination following the general application procedures above. A Medicaid application must be received by the Worker prior to the DHS-2.FRM expiration date. However, the application process does not have to be completed prior to the expiration date.
- If the client does not submit an appropriate Medicaid application form with the yellow DHS-2.FRM, the Worker must send an application to the client.
- If the client does not submit the appropriate Medicaid application form prior to the yellow DHS-2.FRM expiration date, the Worker checks the box indicating the application was not completed and faxes the form back to the UMC.

24.45.2.A.4 Client Determined Financially Eligible for the TBI waiver

If the client is determined financially eligible for the TBI waiver:

- The Worker confirms the pending TBI waiver category. Financial eligibility for the TBI waiver category is pended up to 90 days in the data system awaiting verification of medical eligibility and availability of a funded TBI waiver slot. The client is notified by a system generated letter.
- The Worker checks the box on the yellow DHS-2.FRM indicating the client is financially eligible and faxes the form back to the UMC. This will initiate medical eligibility to be determined by the UMC.

24.45.2.A.5 Client Determined Financially Ineligible for the TBI waiver

If the client is determined financially ineligible for TBI waiver:

- The Worker checks the box on the yellow DHS-2.FRM indicating the client is ineligible and faxes the form back to the UMC.
- The Worker then evaluates for all other Division of Family Assistance (DFA) programs. The client will be sent a denial letter by the eligibility system.

24.45.2.B Step Two: Receipt of the DHHR Referral Form for Medicaid Traumatic Brain Injury Waiver Program (DHS-2.FRM) WHITE FORM

For Step Two of the application process, the white DHS-2.FRM, along with the Notice of Decision letter, confirms to the Worker the client was determined medically-eligible and awarded a funded slot for the TBI waiver program.

The white DHS-2.FRM originates from a case management agency if the client chooses the traditional service delivery model or the personal options delivery model.

24.45.2.B.1 Expired White DHS-2.FRM

If the white DHS-2.FRM form is expired, the Worker checks the box indicating it is expired and faxes the form back to the originating agency. Medicaid is not approved.

24.45.2.B.2 White DHS-2.FRM with Missing Expiration Date

If there is no expiration date on the white DHS-2.FRM, it should be faxed back to the originating agency, noting there is no expiration date. Medicaid is not approved.

24.45.2.B.3 Current (Not Expired) White DHS-2.FRM

If the white DHS-2.FRM is not expired:

- The Worker updates financial eligibility.
    - If TBI waiver financial eligibility was determined in the last 90 days and is in pending status, the Worker updates the system and approves Medicaid TBI waiver program eligibility.
    - If more than 90 days have passed since financial eligibility was determined, the client must be reevaluated for financial eligibility. The Medicaid TBI waiver is not approved. The client must submit a new application prior to the expiration date on the white form.
- The Worker checks the appropriate box on the white DHS-2.FRM indicating whether the client is eligible or ineligible for Medicaid TBI waiver and faxes the form back to the originating agency.
- The client has only 60 days after acquiring a waiver slot to establish eligibility and be enrolled in the waiver program, or they will lose their slot. Timely financial eligibility determinations are critical.

NOTE: When the applicant's eligibility for, or enrollment in, this program is pending, due to the lack of a waiver slot or other reason, he must not be refused the right to apply due to his pending status for the TBI waiver group, but must be evaluated for any or all DFA programs.

> **TBI Application Example:** Mr. Beech applies for the TBI waiver, which requires a medical eligibility decision by the TBI waiver program and a financial determination by an Income Maintenance Worker. While his medical eligibility decision is pending, he visits his local DHHR office and applies for the Supplemental Nutrition Assistance Program (SNAP). Although his medical eligibility for the TBI waiver has not been determined and a financial determination cannot be made by the Worker for the TBI waiver, his pending status for this program does not prevent his evaluation for all other Medicaid groups or DFA programs for which he may qualify.

24.45.3 WAIVER APPLICANTS CURRENTLY RECEIVING MEDICAID PAYMENT FOR NURSING FACILITY SERVICES

For TBI waiver applicants currently receiving Medicaid payment for nursing facility services, the following steps are used.

24.45.3.A Step One: Receipt of the DHHR Referral Form for Medicaid Traumatic Brain Injury Waiver Program, Initiate Financial Eligibility (DHS-2.FRM) YELLOW FORM

The yellow DHS-2.FRM instructs the Worker to determine financial eligibility. The Worker must first evaluate the client's financial eligibility based on the current information in the case record.

Clients currently receiving Medicaid payment for nursing facility services in the Nursing Facility coverage group, or as an SSI or Deemed SSI recipient, have been determined financially eligible and are not required to complete a new Medicaid application upon receipt of the yellow DHS-2.FRM.

All other clients currently receiving Medicaid payment for nursing facility services must submit an appropriate waiver application form prior to the expiration date on the yellow DHS-2.FRM.

24.45.3.A.1 Expired Yellow DHS-2.FRM

If the yellow DHS-2.FRM is expired, the Worker checks the box indicating it is expired and faxes the form back to the TBI waiver UMC.

24.45.3.A.2 Yellow DHS-2.FRM with Missing Expiration Date

If there is no expiration date on the yellow DHS-2.FRM, it should be faxed back to the UMC, noting there is no expiration date.

24.45.3.A.3 Current (Not Expired) Yellow DHS-2.FRM

If the yellow DHS-2.FRM is not expired:

- If the client is currently receiving Medicaid in the Nursing Facility, SSI or Deemed SSI coverage group, the Worker checks the box on the yellow DHS-2.FRM indicating the client is financially eligible and faxes the form back to the UMC. This will initiate medical eligibility to be determined by the UMC.
- If not currently financially eligible, the Worker completes the financial eligibility determination following the general application procedures above. A Medicaid

application must be received by the Worker prior to the DHS-2.FRM expiration date, if applicable. However, the application process does not have to be completed prior to the expiration date.

- If the client does not submit an appropriate Medicaid application form with the yellow DHS-2.FRM the Worker must send an application to the client.
- If the client does not submit the appropriate Medicaid application form prior to the yellow DHS-2.FRM expiration date, the Worker checks the box indicating the application was not completed and faxes the form back to the UMC.

24.45.3.B Step Two: Receipt of the DHHR Referral Form for Medicaid Traumatic Brain Injury Waiver Program (DHS-2.FRM) WHITE FORM

The white DHS-2.FRM, along with the Notice of Decision letter, confirms to the Worker the client was determined medically-eligible and awarded a funded slot for the TBI waiver program.

24.45.3.B.1 Expired White DHS-2.FRM

If the white DHS-2.FRM form is expired:

- The Worker checks the box indicating it is expired and faxes the form back to the originating agency. Medicaid coverage for nursing facility services continues if all requirements are met.
- If there is no expiration date on the white DHS-2.FRM, it should be faxed back to the originating agency, noting there is no expiration date. Medicaid coverage for nursing facility services continues if all requirements are met.

24.45.3.B.2 Current (Not Expired) DHS-2.FRM

If the white DHS-2.FRM is not expired:

- The Worker approves eligibility in the TBI waiver category upon notification the client has been discharged from the nursing facility.
- The Worker checks the appropriate box on the white DHS-2.FRM indicating whether the client is eligible or ineligible for Medicaid TBI waiver and faxes the form back to the originating agency.

The client has only 60 days after acquiring a waiver slot to establish eligibility and be enrolled in the waiver program, or they will lose their slot. Timely financial eligibility determinations are critical.

24.45.4 REDETERMINATION PROCESS

A redetermination of eligibility is completed once a year; a face-to-face interview is not required. The Worker receives an alert in the eligibility system when a redetermination is due. The Worker must manually set an alert to schedule the redetermination for SSI and Deemed SSI waiver clients.

The same financial criteria used at application applies at each annual redetermination. Medical necessity must be verified annually at redetermination with a Notice of Decision letter or document from the UMC stating the client continues to be eligible. If the client continues to meet financial and medical requirements, Medicaid eligibility for waiver services is established. Continued medical eligibility for services is monitored by the Bureau for Medical Services (BMS).

24.46 NOTIFICATION

24.46.1 CLIENT

Notification procedures in Chapter 9 are applicable.

24.46.2 CASE MANAGEMENT AGENCY (CMA)

At application, the Worker sends a copy of the completed white DHS-2.FRM to the originating agency within 30 days of completion of the application. This notifies the originating agency of the financial eligibility decision and provides them with the Medicaid ID. The Worker retains a copy of the completed DHS-2.FRM for the case record.

The Worker must also notify the originating agency when a Traumatic Brain Injury (TBI) waiver client becomes ineligible for any reason, using the original form DHS-2.FRM, a DHS-1, or a free-format letter.

24.47 CASE MAINTENANCE

24.47.1 COUNTY TRANSFER

When a Traumatic Brain Injury (TBI) waiver client moves from one county to another, the case record must be transferred to the new county of residence.

24.47.2 CHANGES IN INCOME

When the client's income increases to above 300% of the Supplemental Security Income (SSI) payment level, he is no longer eligible for TBI waiver services.

The Worker must:

- Notify the case management agency (CMA) or the Bureau for Medical Services (BMS) contract agency listed in Appendix E;
- Notify the client or his authorized representative by providing 13 days' advance notice;
- Update the eligibility system; and,
- Evaluate the client for all other Medicaid coverage groups.

24.47.3 CHANGE IN MEDICAL CONDITION

When the client's medical condition improves to the extent that TBI services are no longer required, he is ineligible for the TBI coverage group. If this is the method by which he qualified for Medicaid, he must be evaluated for all other Medicaid coverage groups. TBI services are no longer paid under Medicaid.

If the TBI client's condition changes to the extent that care in a nursing facility is required, the following conditions must be met before Medicaid can pay for nursing facility services:

- A valid Pre-Admission Screening (PAS) was completed on the date the client entered the nursing facility or within the 60-day period prior to entering the facility.
- The post-eligibility process to determine the client's contribution to his cost of care was completed. See Section 24.7 for instructions.

- All notification procedures outlined in Section 17.6 were followed.
- The redetermination cycle remains the same for the assistance group (AG). When this change occurs in the month of redetermination, it must be completed at the same time as the change from TBI to nursing facility services.
- When the individual is under age 65 and does not receive a disability benefit or meet any other criteria specified in Section 13.4, disability must be established by MRT. See Section 24.12.

24.48 ESTABLISHING MEDICAL NECESSITY

Medical necessity is determined by the Bureau for Medical Services (BMS) Utilization Management Contract (UMC) agency. When the UMC sends the white DHS-2.FRM, along with the Notice of Decision letter, medical necessity is presumed to be determined.

The Worker has responsibility in this process to obtain the letter from the UMC as verification of medical eligibility at application and redetermination.

The BMS, UMC, or case manager notifies the Worker when a client no longer has a medical necessity for Traumatic Brain Injury (TBI) waiver services.

CHILDREN WITH DISABILTIES COMMUNITY SERVICE PROGRAM (CDCSP)

24.49 INTRODUCTION

The Children with Disabilities Community Service Program (CDCSP) is a West Virginia optional Medicaid eligibility category that allows a child under the age of 18 with a severe disability who is eligible to receive necessary medical services while residing in their family (natural or adoptive) homes or communities. The medical services must be more cost-effective for the State than placement in a medical institution, such as a nursing home, intermediate care facility for individuals with intellectual disabilities (ICF/IID), acute care hospital, or approved Medicaid psychiatric facility for children under the age of 21.

This coverage group allows children to remain with their families by providing medical services in the home or community that are more cost-effective than care in a medical institution. It also eliminates the requirement that the income and assets of parents and/or legal guardians be deemed to the children.

A child is eligible for Medicaid as a CDCSP client when all of the following conditions are met:

- The child has not attained the age of 18.
- The child has been denied Supplemental Security Income (SSI) eligibility or appears to be ineligible for SSI eligibility because the income and assets of his parent(s) were deemed to him, and as a result, the SSI income or asset eligibility test was not met.
- The child's own gross income does not exceed 300% of the SSI payment level.
- The child has been determined to require a level of care provided in a medical institution, nursing home, ICF/IID, hospital, or psychiatric facility.
- He is expected to receive the necessary services at home or in the community.
- The estimated cost of services is no greater than the estimated cost of institutionalization.
- The child would be eligible for an SSI payment if in a medical institution.

NOTE: The Worker must refer the family to the Social Security Administration (SSA) to apply for SSI if the family has not done so already, even though the Worker may be able to determine that the SSA would deny the child as a result of deeming the parents' income and/or assets.

The Worker must then obtain a copy of the SSI denial letter and retain it in the case record.

The Bureau for Medical Services (BMS) Long Term Care (LTC) Unit determines medical eligibility and notifies the local office and the case management agency of the decision in writing. Refer to Chapter 13 for details about determining medical eligibility.

24.50 APPLICATION

24.50.1 GENERAL APPLICATION PROCEDURES

24.50.1.A APPLICATION FORMS

The Application for Benefits (DFA-2), the Application for Long Term Care Medicaid and Children with Disabilities Community Service (DFA-MA-1), or the Application for Healthcare Coverage (DFA-SLA-1) with the Supplement for Healthcare Coverage (DFA-SLA-S1) is acceptable. Applications may also be submitted via WV PATH.

When medical eligibility for the Children with Disabilities Community Service Program (CDCSP) is established by the Bureau for Medical Services (BMS) and the Case Management Agency (CMA), a memorandum is sent to the Community Services Manager (CSM). The memorandum is given to the Worker who, with the completed application, determines financial eligibility.

The client must verify he has been denied Supplemental Security Income (SSI).

The following information is provided solely for the understanding of the process and not the responsibility of the worker:

- Additional forms related to medical eligibility and cost of services must also be completed as part of the eligibility determination process. This information is sent directly to the BMS by the CMA. See Section 24.55.
- BMS determines the annual cost of institutionalization, the annual cost of in-home care under the CDCSP, and the cost of the type of services necessary for the child to decide the cost-effectiveness of the proposed in-home plan.
- CDCSP-2A or 2B: This is the medical form the child's physician uses to submit necessary information to allow a determination of medical eligibility.
- CDCSP-6: This is the cost estimate worksheet for medical services that must be completed and used by the CMA to:
    - Assure the program plan is cost feasible (e.g., community services cost less than placement in a medical institution).

- Follow through with the school system, healthcare providers, and other agencies to assure that the community services are implemented and consistently remain cost-effective.
- Develop the Program Plan: The program plan must be developed by an interdisciplinary team (IDT) consisting of the child, family or legal representative, service providers, advocates, professionals, paraprofessionals, and other stakeholders needed to ensure the delivery of the necessary level of services. This contains the same elements of the State DD-5 form.
- Provide additional evaluations: Additional evaluations, as appropriate, to determine medical eligibility and services for the specific disability group, such as psychological or psychiatric reports, social assessments, discharge plan, etc.

When an applicant's medical eligibility for, or enrollment in, this program is pending, he must not be refused the right to apply for any or all Division of Family Assistance (DFA) programs.

24.50.1.B COMPLETE APPLICATION

The application is complete when the parent(s) or legal guardian signs the DFA- 2, DFA-MA-1, or DFA-SLA-1 with the DFA-SLA-S1 application that contains, at a minimum, the client's name and address. When the applicant submits his application by WV PATH, the application is considered complete when the application is signed electronically.

24.50.1.C DATE OF APPLICATION

The date of application is the date the parent(s) or legal guardian submits the DFA-2, DFA-MA-1, or DFA-SLA-1 with the DFA-SLA-S1 application, in person, by fax, or by other electronic transmission or by mail, that contains—at a minimum—his name, address, and signature. When the application is submitted by mail or fax, the date of application is the date that the form with the name, address, and signature is received in the local office. Applications can also be submitted by other

NOTE: When a faxed copy or other electronic transmission of an application is received that contains a minimum of the applicant's name, address, and signature, it is considered an original application, and no additional signature is required.

electronic transmission. When the application is submitted using WV PATH, the date of application is the date the application is submitted.

NOTE: If the applicant completed the interactive interview and there is a technical failure that prevents the printing of the DFA-2, Form DFA-5 must be signed by the applicant and attached and filed in the case record with the subsequently printed DFA-2. Form DFA-RR-1 must also be completed and signed. He must not be required to return to the office to sign the DFA-2 when the DFA-5 has been signed.

24.50.1.D INTERVIEW

No interview is required.

24.50.1.E WHO MUST SIGN

The parent(s) or legal guardian of the child must sign the application. When a complete faxed or scanned application is received, no additional signature is required.

24.50.1.F AGENCY TIME LIMITS

The agency must take action to approve, deny, or withdraw the application within 30 days of the date of application.

The Worker must give the parent(s) or legal guardian at least 10 days for the information to be returned.

24.50.1.G AGENCY DELAYS

When the Department of Health and Human Resources (DHHR) fails to request necessary verification, the Worker must immediately send a verification checklist or form DFA-6 to request it. He must inform the client that the application is being held pending. When the verification is

received, and the client is eligible, medical coverage is retroactive to the time eligibility would have been established had the DHHR acted in a timely manner.

Reimbursement for out-of-pocket expenses may apply. See Chapter 10.

24.50.1.H PAYEE

The CDCSP child is the payee.

24.50.1.I EFFECTIVE DATES OF ELIGIBILITY

Eligibility is retroactive to the later of these two dates:

- The date of medical need, established by the BMS, and conveyed by memorandum to the CSM; or
- The date all eligibility requirements were met, up to three months prior to the application date.

Eligibility ends the last day of the effective calendar month of closure.

24.50.1.J THE BENEFIT

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

24.50.2 REDETERMINATION

The Children with Disabilities Community Service Program (CDCSP) redetermination process is the same as the CDCSP application process, with the following exceptions:

A redetermination of financial eligibility is completed annually. The Worker must notify the health care provider (e.g., behavioral health center, childcare agency, early intervention program) that is providing case management services, and the family or legal guardian, when the case is due for redetermination.

Medical eligibility must be redetermined annually by the Bureau for Medical Services (BMS). The case does not continue to be eligible after the redetermination unless both financial and medical eligibility are redetermined.

24.50.2.A DATE OF REDETERMINATION

There is a 12-month redetermination cycle for the CDCSP assistance groups (AGs).

The eligibility system generates the redetermination form.

24.51 COMMON ELIGIBILITY REQUIREMENTS

Children with Disabilities Community Service Program (CSCSP) coverage groups use the same common eligibility requirements as Supplemental Security Income (SSI)-Related Medicaid. See Chapter 2.

24.52 ELIGIBILITY DETERMINATION GROUPS

24.52.1 THE ASSISTANCE GROUP (AG)

Only the Children with Disabilities Community Services Program (CDCSP) child is included in the AG.

24.52.2 THE INCOME GROUP (IG)

Only the CDCSP child's income is counted. Income of the parent(s) is not deemed or counted in any way.

24.52.3 THE NEEDS GROUP (NG)

Only the CDCSP child's needs are considered.

24.53 INCOME

The determination of which income sources to count is the same as Supplemental Security Income (SSI)-Related Medicaid. See Chapter 4. No income is deemed to the Children with Disabilities Community Service Program (CDCSP) client. The client's monthly gross countable income must be equal to or less than 300% of the maximum (SSI) payment for a single individual to be Medicaid-eligible. There is no post-eligibility process for this coverage group.

NOTE: The spenddown provision does not apply.

24.53.1 INCOME DISREGARDS AND DEDUCTIONS

No income disregards or deductions are applied to the child's countable income.

24.53.2 DETERMINING FINANCIAL ELIGIBILITY

The Worker determines the child's own total countable income from all sources and compares it to 300% of the SSI payment level. If the income is equal to or less than 300% of the SSI payment level, the child is financially eligible.

24.54 ASSETS

The determination of countable assets is the same as for Supplemental Security Income (SSI)-Related Medicaid. See Chapter 5.

Assets are not deemed for this group.

Only the child's assets are counted.

The asset limit for one person is used.

The asset limit for Children with Disabilities Community Services Program (CDCSP) is $2,000.

24.55 NOTIFICATION

Notification procedure in Chapter 9 are applicable.

24.56 CASE MAINTENANCE

24.56.1 COUNTY TRANSFER

When a Children with Disabilities Community Service Program (CDCSP) client moves from one county to another, the case record must be transferred to the new county of residence.

24.56.2 CHANGES IN INCOME

When the client's income increases to above 300% of the Supplemental Security Income (SSI) payment level, he is no longer eligible for CDCSP. The Worker must:

- Notify the case management agency;
- Notify the client or his authorized representative by providing 13 days' advance notice;
- Update the eligibility system; and,
- Evaluate the client for all other Medicaid coverage groups.

24.56.3 CHANGE IN MEDICAL CONDITION

When the client's medical condition improves to the extent that institutional-level services are no longer required, he is ineligible for the CDCSP. He must be evaluated for all other Medicaid coverage groups.

24.56.4 CHILD REACHING AGE 18

At age 18, individuals must apply for SSI. If SSI-eligible, they receive SSI Medicaid and no longer receive coverage as a CDCSP client.

Individuals who reach age 18 continue to receive the services until approved for SSI or reach age 19, whichever occurs first.

No individual who has attained age 18 is approved for CDCSP at application.

24.57 ESTABLISHING MEDICAL NECESSITY AND COST EFFECTIVENESS

Information establishing medical necessity and cost effectiveness of services is sent directly to the Bureau for Medical Services (BMS) by the case management agency.

When medical eligibility for the Children with Disabilities Community Service Program (CDCSP) is established by the BMS, a memorandum is sent to the Community Services Manager (CSM).

24.58 BILLING PROCEDURES AND PAYMENT AMOUNTS

Payments to case management agencies are handled by the Department of Health and Human Resources' (DHHR') contract agency that handles provider services. All inquiries from case management agencies, service providers, or vendors about billing must be referred to Provider Services. See Appendix E.

APPENDIX A: REMAINDER INTEREST TABLES

Age	Remainder
0	.02812
1	.01012
2	.00983
3	.00992
4	.01019
5	.01062
6	.01116
7	.01178
8	.01252
9	.01337
10	.01435
11	.01547
12	.01671
13	.01802
14	.01934
15	.02063
16	.02185
17	.02300
18	.02410
19	.02520
20	.02635
21	.02755
22	.02880
23	.03014
24	.03159
25	.03322
26	.03505
27	.03710
28	.03938
29	.04187

Age	Remainder
30	.04457
31	.04746
32	.05058
33	.05392
34	.05750
35	.06132
36	.06540
37	.06974
38	.07433
39	.07917
40	.08429
41	.08970
42	.09543
43	.10145
44	.10779
45	.11442
46	.12137
47	.12863
48	.13626
49	.14422
50	.15257
51	.16126
52	.17031
53	.17972
54	.18946
55	.19954
56	.20994
57	.22069
58	.23178
59	.24325

Age	Remainder
60	.25509
61	.26733
62	.27998
63	.29304
64	.30648
65	.32030
66	.33449
67	.34902
68	.36390
69	.37914
70	.39478
71	.41086
72	.42739
73	.44429
74	.46138
75	.47851
76	.49559
77	.51258
78	.52951
79	.54643
80	.56341
81	.58033
82	.59705
83	.61358
84	.63002
85	.64641
86	.66236
87	.67738
88	.69141
89	.70474

Age	Remainder
90	.71779
91	.73045
92	.74229
93	.75308
94	.76272
95	.77113
96	.77819
97	.78459
98	.79000
99	.79514
100	.80025
101	.80468
102	.80946
103	.81563
104	.82144
105	.83038
106	.84512
107	.86591
108	.89932
109	.95455

APPENDIX B: PATIENTS' RIGHTS

A policy statement setting forth the rights of patients and prohibiting their mistreatment or abuse is established and made available to staff, patients' families, or legal representatives. Written policies and procedures ensure that each patient admitted to the facility is fully informed of his/her rights and responsibilities as a patient in the facility.

A. NOTICE OF RIGHTS

1. Inform each patient of all rules and regulations governing patient conduct and responsibilities. Such information must be provided prior to or at the time of admission or, in the case of patients already in the facility, upon the facility's adoption or amendment of resident right's policies, and its receipt must be acknowledged by the patient in writing. In the case of a mentally retarded individual or of a patient adjudged to be incompetent, the rights described in this provision shall be exercised by the individual's guardian or committee, as applicable under State Law, to act on the patient's behalf.
2. Encourage and assist the patient throughout the period of stay to exercise rights as a patient and a citizen and, to this end, to meet and organize with resident groups, voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of choice free from restraint, interference, coercion, discrimination, or reprisal.
3. Assist each patient to retain and use his/her personal clothing and possessions as space permits.
4. May not require the patient to perform services for the facility.
5. Assure participation in activities of social, religious and community groups at the patient's discretion unless contraindicated for reasons documented by a Qualified Mental Retardation Professional as appropriate in the patient record.

B. NOTICE OF CHARGES FOR SERVICES

1. Inform each patient in writing who is entitled to Medicaid, prior to or at the time of admission and periodically during the patient's stay, of services available in the facility and of related charges, including any charges for services not covered under the Medicaid Program, or not covered by the facility's basic per diem rate. Only charges by the facility for items or services that are allowable and consistent with the Medicaid Program regulations may be imposed.
2. Maintain admission policies and procedures which do not require patients to waive their rights to apply for Medicaid benefits and do not require third party guarantee of payment to the facility as a condition of admission to, or continued stay in the facility.

3. Provide information to each patient, patient's family, and/or patient's representative concerning the availability of assets assessments. Advise them that these assets assessments are available upon request at the county Department of Health and Human Resources (DHHR) office whether or not they are applying for Medicaid.

C. FREE CHOICE

Inform each patient of the right to choose a personal attending physician; to be fully informed by the physician of his/her health and medical condition unless medically contraindicated (as documented by a physician in the patient medical record) and of changes in care and treatment. The patient must be offered the opportunity to participate in the planning of his/her total care and medical treatment and participates in experimental research only upon his/her informed written consent.

D. TRANSFER AND DISCHARGE RIGHTS

Transfers and discharges are made only for medical reasons or for the patient's welfare or that of other patients or for nonpayment for stay in the facility, except as prohibited by the Medicaid Program. In a case where the patient's health improves sufficiently so that services provided by the facility are no longer needed, sufficient notice must be provided to the patient and/or family and for adequate discharge planning.

E. PROTECTION OF PATIENT FUNDS

Assure the patient's right to manage his/her personal financial affairs; except, upon written authorization by the patient, the facility will accept responsibility for managing and accounting for the patient's personal funds and records of such funds. A full and complete accounting must be made available to patients and their families, and is maintained on a current basis for each patient with written receipts for all personal possessions and funds received by or deposited with the facility and for all disbursements made to or on behalf of the patient.

F. FREEDOM FROM RESTRAINTS

1. Assurance of freedom from mental and physical abuse, corporal punishment, involuntary seclusion and freedom from chemical and physical restraints for the purpose of discipline or convenience. Restraints may only be imposed when authorized in writing by a physician for a specific period of time; or, when necessary in an emergency to protect the patient from injury to himself or to others, in which case restraints may be authorized by designated professional personnel who promptly report the action taken to the physician or qualified mental retardation professional for use during behavior modification sessions.
2. A mentally retarded individual participates in a behavior modification program involving use of restraints or aversive stimuli only with the informed consent of his parent or guardian.

G. CONFIDENTIALITY

1. Ensure confidential treatment of all information contained in patient records including information contained in an automatic data bank; and obtain the patient's written consent for the release of information to persons not otherwise authorized under law to receive it.
2. Permit the patient access to his medical records in accord with State law.

H. PRIVACY

1. Assure each patient is treated with consideration, respect, and full recognition of his/her dignity and individuality including privacy in treatment and in care for his personal needs.
2. Ensure the patient's right to communicate, associate, and meet privately with persons of choice unless to do so would infringe upon the rights of other patients, and to send and receive personal mail unopened or censored.
3. Permit access to any patient representatives of the Secretary, DHHR, or the State, officially designated Ombudsman, and the patient's attending physician, consistent with State and federal law; and permit access to any patient by the immediate family, or other relatives, subject to the patient's right to deny or withdraw consent at any time; and permit reasonable access to a patient by any entity or individual that provides social or legal services to the patient, subject to the patient's right to deny or withdraw consent at any time.
4. Ensure privacy for spousal visits, and if both are residents in the facility, they are permitted to share a room.

I. RIGHTS OF INCOMPETENT PATIENTS

Written policies provide that all rights and responsibilities of the patient devolve to the patient's guardian, next of kin, or sponsoring agency, where:

1. A patient is adjudicated incompetent in accordance with State law; and
2. His physician or, in the case of a mentally retarded individual, a qualified mental retardation professional has documented in the patient's record the specific impairment that has rendered the patient incapable of understanding these rights.

APPENDIX C: PERIOD LIFE TABLES (HISTORICAL)

Historical – For use for annuities purchased prior to February 8, 2006 only.

MALES

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

Historical – For use for annuities purchased prior to February 8, 2006 only.

FEMALES

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

APPENDIX D: PERIOD LIFE TABLES

For use with annuity-related transfers after February 8, 2006. See Section 24.6.

Period Life Table, 2013

(As determined in accordance with actuarial publications of the Office of Chief Actuary of the Social Security Administration)

MALES

Age	Expectancy	Age	Expectancy	Age	Expectancy	Age	Expectancy	Age	Expectancy
0	76.28	24	53.4	48	31.32	72	12.92	96	2.64
1	75.78	25	52.47	49	30.44	73	12.27	97	2.49
2	74.82	26	51.54	50	29.58	74	11.65	98	2.36
3	73.84	27	50.61	51	28.73	75	11.03	99	2.24
4	72.85	28	49.68	52	27.89	76	10.43	100	2.12
5	71.87	29	48.75	53	27.05	77	9.85	101	2.01
6	70.88	30	47.82	54	26.23	78	9.28	102	1.9
7	69.89	31	46.89	55	25.41	79	8.73	103	1.8
8	68.9	32	45.96	56	24.61	80	8.2	104	1.7
9	67.9	33	45.03	57	23.82	81	7.68	105	1.6
10	66.91	34	44.1	58	23.03	82	7.19	106	1.51
11	65.92	35	43.17	59	22.25	83	6.72	107	1.42
12	64.92	36	42.24	60	21.48	84	6.27	108	1.34
13	63.93	37	41.31	61	20.72	85	5.84	109	1.26
14	62.94	38	40.38	62	19.97	86	5.43	110	1.18
15	61.96	39	39.46	63	19.22	87	5.04	111	1.11
16	60.99	40	38.53	64	18.48	88	4.68	112	1.04
17	60.02	41	37.61	65	17.75	89	4.34	113	0.97
18	59.05	42	36.7	66	17.03	90	4.03	114	0.9
19	58.09	43	35.78	67	16.32	91	3.74	115	0.84
20	57.14	44	34.88	68	15.61	92	3.47	116	0.78
21	56.2	45	33.98	69	14.92	93	3.23	117	0.72
22	55.27	46	33.08	70	14.24	94	3.01	118	0.67
23	54.33	47	32.19	71	13.57	95	2.82	119	0.61

FEMALES

Age	Expectancy
0	81.05
1	80.49
2	79.52
3	78.54
4	77.55
5	76.56
6	75.57
7	74.58
8	73.58
9	72.59
10	71.6
11	70.6
12	69.61
13	68.62
14	67.63
15	66.64
16	65.65
17	64.67
18	63.68
19	62.7
20	61.72
21	60.75
22	59.77
23	58.8
24	57.82
25	56.85
26	55.88

Age	Expectancy
27	54.91
28	53.94
29	52.97
30	52.01
31	51.04
32	50.08
33	49.11
34	48.15
35	47.19
36	46.23
37	45.28
38	44.33
39	43.37
40	42.43
41	41.48
42	40.54
43	39.6
44	38.66
45	37.73
46	36.81
47	35.89
48	34.97
49	34.06
50	33.16
51	32.27
52	31.38
53	30.49

Age	Expectancy
54	29.62
55	28.74
56	27.88
57	27.01
58	26.16
59	25.31
60	24.46
61	23.62
62	22.78
63	21.95
64	21.13
65	20.32
66	19.52
67	18.73
68	17.95
69	17.18
70	16.43
71	15.68
72	14.95
73	14.23
74	13.53
75	12.83
76	12.16
77	11.5
78	10.86
79	10.24
80	9.64

Age	Expectancy
81	9.05
82	8.48
83	7.94
84	7.42
85	6.92
86	6.44
87	5.99
88	5.57
89	5.17
90	4.8
91	4.45
92	4.13
93	3.84
94	3.57
95	3.34
96	3.12
97	2.93
98	2.76
99	2.6
100	2.45
101	2.3
102	2.17
103	2.03
104	1.91
105	1.78
106	1.67
107	1.56

Age	Expectancy
108	1.45
109	1.35
110	1.26
111	1.17
112	1.08
113	1
114	0.92
115	0.85
116	0.78
117	0.72
118	0.67
119	0.61

APPENDIX E: CONTRACT AGENCY LISTING

The following contains contact information for the current contract agencies for LTC coverage groups and Medical necessity questions, Estate Recovery, Annuity and Trusts reporting, and Payment and Billing issues.

Estate Recovery and Annuities and Trusts	Health Management Services (HMS) Phone: (304) 342-1604 Fax: (304) 342-1605	
Payment and Billing Issues	DXC Healthcare	
	DXC Provider Services (888) 483-0793	DXC Member Services (888) 483-0797

Contract Agency Listings		
	Utilization Management Contract Agency	Medical Necessity Determination
TBI Waiver	KEPRO – ASO 100 Capitol Street, Suite 600 Charleston, WV 25301 800.346.8272 Phone: (866) 385-8920 Fax: (866) 607-9903 General Email: WVTBIWaiver@kepro.com	KEPRO Phone: (866) 385-8920 Fax: (866) 607-9903 General Email: WVTBIWaiver@kepro.com
I/DD Waiver	KEPRO Toll-Free: (866) 385-8920 Phone: (304) 380-0617 Fax: (866) 521-6882 General Email: WVIDDWaiver@kepro.com	Psychological Consultation and Assessment, Inc. (PC&A) Phone: (304) 776-7230 Fax: (304) 776-7247 There is no general email box for PC&A for I/DD services.
AD Waiver	KEPRO Phone: (844) 723-7811 Fax: (866) 212-5053 Email: WVADWaiver@kepro.com	KEPRO Phone: (844) 723-7811 Fax: (866) 212-5053 Additional Information for PAS: ADWDocumentation@kepro.com
Nursing Facility		KEPRO

Contract Agency Listings		
Utilization Management Contract Agency		Medical Necessity Determination
		Phone: (844) 723-7811 Fax: (844) 633-8425 General Email: WVPAS@kepro.com
ICF/IID	Psychological Consultation and Assessment, Inc. (PC&A) 202 Glass Drive Cross Lanes, WV 25313	Psychological Consultation and Assessment, Inc. (PC&A) Phone: (304) 776-7230 Fax: (304) 776-7247 Email: rworkman@pcasolutions.com or shudson@pcasolutions.com
Personal Care	KEPRO Phone: (844) 723-7811 Fax: (866) 212-5053 General Email: WVPersonalCare@kepro.com	
BoSS	Bureau of Senior Services (BoSS) 1900 Kanawha Boulevard, East Charleston, WV 25305 Phone: (304) 558-3317	

APPENDIX F: LONG TERM CARE INSURANCE PARTNERSHIP (LTCIP) STATES' IMPLEMENTATION DATES

EFFECTIVE DATE

The date that the U.S. Department of Health & Human Services approves the State Plan Amendment. Original Partnership indicates one of the four original Partnership States.

RECIPROCITY

Whether or not the State will honor partnership policies from other DRA partnership states when it comes to allowing asset disregard when filing for Medicaid. All DRA states plus New York, Indiana and Connecticut have reciprocity. California does not.

State	Effective Date	Policy Reciprocity
Alabama	03/01/2009	Yes
Alaska	Not Filed	---
Arizona	07/01/2008	Yes
Arkansas	07/01/2008	Yes
California	Original Partnership	No
Colorado	01/01/2008	Yes
Connecticut	Original Partnership	Yes
Delaware	11/01/2011	Yes
District of Columbia	Not Filed	---
Florida	01/01/2007	Yes
Georgia	01/01/2007	Yes
Hawaii	Pending	---
Idaho	11/01/2006	Yes
Illinois	Pending	---
Indiana	Original Partnership	Yes
Iowa	01/01/2010	Yes
Kansas	04/01/2007	Yes
Kentucky	06/16/2008	Yes

State	Effective Date	Policy Reciprocity
Louisiana	10/01/2009	Yes
Maine	07/01/2009	Yes
Maryland	01/01/2009	Yes
Massachusetts	Proposed	---
Michigan	10/01/2013	Yes
Minnesota	07/01/2006	Yes
Mississippi	Not Filed	---
Missouri	08/01/2008	Yes
Montana	07/01/2009	Yes
Nebraska	07/01/2006	Yes
Nevada	01/01/2007	Yes
New Hampshire	02/16/2010	Yes
New Jersey	07/01/2008	Yes
New Mexico	Not Filed	---
New York	Original Partnership	Yes
North Carolina	03/07/2011	Yes
North Dakota	01/01/2007	Yes
Ohio	09/10/2007	Yes
Oklahoma	07/01/2008	Yes
Oregon	01/01/2008	Yes
Pennsylvania	09/15/2007	Yes
Rhode Island	07/01/2008	Yes
South Carolina	01/01/2009	Yes
South Dakota	07/01/2007	Yes
Tennessee	10/01/2008	Yes
Texas	03/01/2008	Yes
Utah	Not Filed	---
Vermont	Not Filed	---
Virginia	09/01/2007	Yes

State	Effective Date	Policy Reciprocity
Washington	01/01/2012	Yes
West Virginia	07/01/2010	Yes
Wisconsin	01/01/2009	Yes
Wyoming	06/29/2009	Yes