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daily contribution rate. The result is the client's total cost contribution for the partial month. After all computations have been completed, any cents calculated as part of the result are dropped.

**NOTE:** 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, even if they are bed-hold days, are not considered for the purpose of prorating the last month's contribution.

**NOTE:** 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 contribute his full resource and be reimbursed by the facility if an overpayment occurs.

When the client's contribution for the initial month of eligibility is prorated, the full month's income and post-eligibility deductions are entered in the data system. No prorated amounts are entered. The Worker notifies the LTC Unit of the prorated amount and the following full month's contribution using the **DFA**-NH-3.

When a client is eligible for payment for nursing facility services under a full-Medicaid coverage group, and is also QMB eligible, he must pay his full 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, an ES-NH-3 must be completed to change the contribution to $0 for that month. See Section 17.9,C for individuals who are eligible for QMB coverage only.

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

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

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

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

C. FINANCIAL ELIGIBILITY PROCESS

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

1. QMB Eligible

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. The QMB medical card pays all Medicare co-insurance and deductibles, and QMB recipients are exempt by law from the post-eligibility process. They, therefore, have no contribution toward their cost of nursing facility services as long as Medicare participates in the payment. See Chapter 16.

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

2. Client Is Medicaid Recipient

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

**NOTE:** SSI, Deemed SSI and other full coverage Medicaid recipients must complete the DFA-LTC-5 at application for LTC services to evaluate any annuities, trusts and/or other potential resources or transfers. See Section 17.12,D.

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Post-Eligibility

| | | |
|---|---|---|
| Community Spouse Deduction: | $ 600.00 | Shelter |
| | + 347.00 | SUA |
| | $ 947.00 | Total Shelter/Utilities |
| | - 591.00 | 30% Min. SMS |
| | $ 356.00 | Excess Shelter/Utilities |
| | + 1,967.00 | Min. SMS |
| | $ 2,323.00 | |
| | - 950.00 | Total gross monthly non-excluded income of Community Spouse |
| | $1,373.00 | CSMA (rounded up per 17.9,D,1,b, Step 5) |
| Family Maintenance Deduction: | $1,967.00 | Min. SMS |
| | - 585.00 | Income |
| | $1,382.00 | Remainder ÷ 3 = $452.00 FMA (rounded up per 17.9,D,1,c, Step 2) |

| | |
|---|---|
| $2,050.00 | Income |
| - 50.00 | Personal Needs |
| $2,000.00 | Remainder |
| - 1,373.00 | CSMA |
| $ 627.00 | Remainder |
| - 415.00 | FMA |
| $ 212.00 | Remainder |
| - 158.50 | Medicare premium and doctor bill |
| $ 55.50 | Resource and total contribution toward his care |

The client has a $55.50 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.

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## 17.10 ASSETS

A nursing care client must meet the asset test for his eligibility coverage group. The asset level for those eligible by having income equal to or less than 300% of the monthly SSI payment for an individual is the same as for an SSI-Related Medicaid eligible. 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. When both spouses are institutionalized and apply for nursing facility services, the SSI-Related Medicaid asset limit for a couple is used to determine eligibility. An asset assessment is not completed when both spouses are institutionalized. See Chapter 11 for the asset limit of the appropriate coverage group.

Once the Worker determines the value of the assets, an Asset Assessment, described in item A below, is completed when an institutionalized person has a spouse in the community.

**NOTE:** Once Medicaid eligibility is established, the assets of the community spouse 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 him, no penalty is applied to the institutionalized spouse.

A. ASSET ASSESSMENTS

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

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

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