MANUAL MATERIAL TRANSMITTED					
MANUAL: INCOME MAINTENANCE			CHANGE NUMBER: 177		
DELETE			INSERT OR CHANGE		
PAGES	CHAPTER	DATED	PAGES	CHAPTER	DATED
APPENDIX A	10	6/2000	APPENDIX A	10	7/2000
i - ii	17	8/98	i - ii	17	7/2000
1 - 4	17	8/98	1	17	8/98
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41 - 47	17	8/98	41	17	8/98
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			96	17	9/95
DATE: JULY, 2000		TO: ALL INCOME MAINTENANCE MANUAL HOLDERS			

Effective July 1, 2000, for Long Term Care cases, the minimum Spousal Maintenance Standard SMS) is $1,407 and the maximum Family Maintenance Allowance (FMA) is $469.

In addition, the Personal Needs Allowance (PNA) for Long Term Care cases will increase from $30 to $50 effective July 1, 2000.

All appropriate material and examples in Chapter 17 have been updated to the new SMS, FMA and PNA amounts. Chapter 10, Appendix A, was updated with the new SMS and FMA amounts.

RAPIDS will run Mass Change for MLTI and MLTN AG's on June 9, 2000, effective July 1, 2000. A reference table change, effective July, will apply to all determinations made for July and thereafter. The AG's Affected by Mass Change report and the Mass Change Exception Listing will be available on MOBIUS on June 12, 2000. Cases which appear on the Mass Change Exception Listing must be reviewed by the Worker and updates completed when appropriate. All updates must be completed effective July, 2000.

The maximum SMS, as well as the minimum and maximum Asset Assessment limits, are updated effective January.

APPENDIX A - INCOME LIMITS

NUMBER OF PERSONS	100% FPL	120% FPL	133% FPL	150% FPL	185% FPL	200% FPL	300% FPL	AFDC MEDICAID LIMIT	WVW PAYMENT	100% SON	185% SON	TRIP
1	696	835	926	1,044	1,288	1,392	2,088	149	249	581	1,075	532
2	938	1,125	1,247	1,407	1,735			201	301	786	1,454	789
3	1,180		1,569	1,769	2,182			253	353	991	1,834	864
4	1,421		1,890	2,132	2,629			312	412	1,196	2,213	939
5	1,663		2,212	2,494	3,076			360	460	1,401	2,592	1,014
6	1,905		2,533	2,857	3,523			413	513	1,606	2,971	1,089
7	2,146		2,854	3,219	3,970			462	562	1,811	3,351	1,164
8	2,388		3,176	3,582	4,417			477	577	2,016	3,730	1,239
9	2,630		3,497	3,944	4,864			477	577	2,221	4,109	1,314
10	2,871		3,819	4,307	5,312			477	577	2,426	4,488	1,389

NUMBER OF PERSONS	MAXIMUM COUPON ALLOTMENT	FOOD STAMP GROSS/NET TEST			MNIL		QMB	SLIMB	QI-1	QI-2	SSI MAX	EMER. ASST.	LIEAP
		GROSS	NET	E & D	1 Mo.	6 Mos.							
1	127	893	687	1,133	200	1,200	696	697-835	836-933	934-1218	512	355	756
2	234	1,199	922	1,521	275	1,650	938	939-1125	1126-1257	1258-1641	769	533	1,014
3	335	1504	1,157	1,909	290	1,740						566	1,273
4	426	1,810	1,392	2,297	312	1,872						711	1,531
5	506	2,115	1,627	2,684	360	2,160						819	1,790
6	607	2,421	1,862	3,072	413	2,478						939	2,048
7	671	2,726	2,097	3,460	461	2,766						1,046	2,307
8	767	3,032	2,332	3,848	477	2,862						1,165	2,565
9	863	3,338	2,567	4.236	527	3,162						1,273	2,824
10	959	3,644	2,802	4,624	577	3,462						1,394	3,082

NURSING HOMES

Min. SMS - $1,407

Max. SMS - $2,103

MAX. FMA/each - $469

OLE - $175

5 - 16 - 22 - 29 - 50 - 55 60 - 72 - 79 - 86 - 93 - 97 - 104 - 110 - 115 - 121 - 134 - 142 - 150 - 157 - 161 - 163 - 162 - 170 - 175 - 177

17.1 INTRODUCTION

This Chapter describes the Department's policies and procedures for determining long-term care eligibility. Nursing facility (long-term care) services are provided to eligible Medicaid individuals who reside in a nursing care or ICF/MR facility.

In addition to providing nursing facility services to eligible Medicaid recipients, two coverage groups are eligible for alternative long-term care services by virtue of their need for nursing care and the availability of home-based or community-based nursing care services. These two coverage groups are part of the same Title XIX Waiver, even though they were begun at different times. The coverage group for elderly or disabled people is the HCB Waiver; the other is for mentally retarded or developmentally disabled individuals who live in facilities within their own communities and is the MR/DD Waiver.

This Chapter is organized the same way the entire Income Maintenance Manual is. Information in other sections of the Manual that also apply here are not repeated. Instead, reference is made to such information.

In determining eligibility for payment of nursing or alternative care, the Worker must ensure that the client, or his representative, is fully informed of the policies and procedures. This is necessary so that the client, his family or his representative is able to make informed decisions about the client's financial affairs.

However, the Worker must not, under any circumstances, suggest or require that the client, or 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 situation. This includes comments about Estate Recovery. The Worker may respond to general questions, but must refer the client, or representative to BMS, for specific information. The Worker must not contact BMS on behalf of the client, but must refer the client or representative to BMS.

The Worker must refer all inquiries about billing issues from the nursing or ICF/MR facility to the LTC Unit in BMS. The Worker must not contact BMS on behalf of the provider, but must refer the provider to BMS.

Questions from county staff about any aspect of long-term care cases must be directed to the IM Policy Unit in OFS, not to BMS.

NURSING FACILITY SERVICES

Section 17.11 contains specific information about the PAS-2000 and details specific situations in which the progress notes or orders are used. Additional examples are also found in Section 17.11.

Payment for nursing facility services may be backdated for up to 3 months prior to the month of application, provided all of the conditions described above are met for that period.

EXAMPLE: An individual is a patient in a hospital. The physician recommends nursing facility care to the patient's family and completes a PAS-2000 dated 6/5/95. The family is undecided about placing the individual in a nursing facility and takes the patient home to provide care. They do not apply for Medicaid until 8/16/95 which is the date the client enters the nursing facility. Medicaid eligibility is established beginning 8/1/95, but the PAS-2000 has expired. A new PAS-2000 is not completed until 8/22/95. Medicaid nursing care payments begin 8/22/95.

EXAMPLE: Same situation as above except that the PAS-2000 is dated 6/25/95. A new PAS-2000 is not required, but nursing facility payments cannot begin until 8/16/95, which is the date he entered the nursing facility.

EXAMPLE: An individual enters a nursing facility on 8/16/95 and the PAS-2000 is signed 8/16/95. However, the client does not become Medicaid eligible until 9/1/95 due to excess assets. Payment for nursing facility services begins 9/1/95.

EXAMPLE: An individual enters a nursing facility on 10/10/95 and a PAS-2000 is signed on that date. On 11/25/95 his family applies for Medicaid to pay for his nursing care costs. Medicaid eligibility is backdated to 8/1/95 to cover the cost of his recent hospitalization. Payment for nursing facility services begins on 10/10/95.

NURSING FACILITY SERVICES

4. SSI-Related Medicaid Test

If the client is not eligible under items 1, 2 or 3 above, his eligibility as an SSI-Related Medicaid client must be explored as another way to receive financial assistance for the cost of nursing facility services.

All policies and procedures in effect for other SSI-Related cases apply to these cases, including the determination of a spenddown amount, if applicable.

EXCEPTIONS:

- Income is not deemed.
- The MNIL for one person is always used. See Chapter 10, Appendix A.
- The spenddown amount is determined on a monthly basis.

When the client's monthly cost of care exceeds his monthly spenddown amount, the spenddown is assumed to be met and Medicaid eligibility is established. In addition, if his monthly spenddown amount exceeds his monthly cost of care, he may become eligible for Medicaid based on a 6-month POC, but not for payment of nursing facility services.

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

NOTE: Only for cases with a community spouse -- the amount of the spenddown is used only for comparison with the cost of care. It is not used as a part of the client's contribution toward his cost of care as it is for all other nursing facility cases which must meet a spenddown.

Step 2: Multiply the number of days the client was in Facility #1 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 Facility #1.

If Step 1 is greater than Step 2, the Step 2 amount is paid to Facility #1 and the difference between Step 1 and Step 2 is paid to Facility #2.

E. EXAMPLES

EXAMPLE: Single Individual with OLE, Categorically Needy

A Pass-Through Medicaid recipient enters a nursing home and wants Medicaid to pay toward his cost of care. He has $1,500/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 recipient. Therefore, only post-eligibility calculations must be performed. The Worker records that the client was a Deemed SSI Recipient prior to nursing care eligibility so that eligibility may be restored if he no longer requires nursing care. Post-eligibility calculations are as follows:

$1,600	Client's gross monthly non-excluded income
- 50	Personal Needs Allowance
$1,550	Remainder
- 175	OLE
$1,375	Client's resource amount which is also his total contribution toward his cost of care.

NURSING FACILITY SERVICES

EXAMPLE: Single Individual Without OLE, Medically Needy

Same as above except the client has no OLE. The client's spenddown amount is the same as determined above.

	Post-Eligibility
$1,600	Income
- 50	Personal Needs Allowance
$1,550	Remainder
- 46	Medicare premium (non-reimbursable medical expense)
$1,504	Remainder
-1,380	Spenddown (non-reimbursable medical expense)
$ 124	Resource Amount

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

$1,380	Spenddown
+ 124	Resource Amount
$1,504	Total Contribution

EXAMPLE: Married Individual Without Community Spouse, Medically Needy

Mr. Smith is married but has been separated from his wife for 10 years. He has 1 dependent child still living in his home. His monthly income is $1,570. He has non-reimbursable medical expenses of $46 (Medicare premium).

	Eligibility
$1,570	Income
- 20	SSI Disregard
$1,550	Remainder
- 200	MNIL
$1,350	Monthly Spenddown

NURSING FACILITY SERVICES

		Post-Eligibility
Community Spouse Deduction:	$ 421	Shelter
	+ 246	SUA
	$ 667	Total Shelter/Utilities
	- 423	30% Min. SMS
	$ 244	Excess Shelter/Utilities
	+1,407	Min. SMS
	$1,651	
	- 640	Total gross monthly non-excluded income of Community Spouse
	$1,011	CSMA
Family Maintenance Deduction:	$1,407	Min. SMS
	- 275	Income
	$1,132	Remainder ÷ 3 = $378 FMA

$1,705	Income
-50	Personal Needs
$1,655	Remainder
1,011	CSMA
$ 644	Remainder
-378	FMA
$ 266	Remainder
-142	Medicare premium and doctor bill
$ 124	Resource and total contribution toward his care

The client has a $124 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.

NURSING FACILITY SERVICES

C. HOMESTEAD PROPERTY EXCLUSION

When a nursing facility resident indicates his intention of returning to his homestead property when/if discharged, the homestead property is excluded as an asset. If the client is incapable of indicating his intent, his Committee, legal representative or the person handling his finanical matters will make the determination on his behalf. When the client's spouse or dependent relative resides there, 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 upon the institutionalized preson. The following are considered relatives of the institutionalized person: child, stepchild or grandchild; parent, stepparent or grandparent; aunt, uncle, niece or nephew; brother or sister, including relations of step or half; cousin or in-law.

It is not necessary that the client be medically able to return home to apply the exclusion. The exclusion is based solely on the client's intended action, should he be discharged from the facility. The Worker must record the client's statement of 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.

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.

The homestead property may 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 8.

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.

NURSING FACILITY SERVICES

The PAS-2000 is completed when:

- The individual enters a Medicaid certified facility.

- The individual transfers from one facility to another. Each facility, i.e., building, must have an original approved PAS-2000 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-2000 for the first facility.

- The individual is admitted to an acute care facility and returns to the same facility, after 60 days.

- The individual's condition changes to the extent that he no longer requires nursing facility services.

When a nursing facility resident is admitted to an acute care facility, moves to a distinct part of the facility which provides nursing facility services, and returns to the original nursing facility, special PAS-2000 procedures apply, depending on individual circumstances. Distinct part, as used in the following, means the part of the acute facility which provides nursing facility services. The special PAS-2000 procedures are:

- The individual moves from the acute care facility to a Medicare-only distinct part. No new PAS-2000 is required for the distinct part. However, a new PAS-2000 is required when the individual returns to the original nursing facility.

- The individual moves from the acute care facility to a distinct part which is dually certified for Medicare and Medicaid. Two PAS-2000's are required, one when the client enters a distinct part and another when he returns to the original nursing facility.

When nursing facility care is approved for a limited time, a new PAS-2000 must be submitted by the facility before the end of the approved period, or the payment for nursing facility services cannot continue beyond that period.

NURSING FACILITY SERVICES

When the PAS-2000 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.

2. Procedures Related To The PAS-2000

   a. Who Originates the PAS-2000

      The originating provider of the PAS-2000 may include, but is not limited to, a hospital, physician, nursing facility or waiver agency.

   b. Responsibilities of the Originating Provider

      - To submit the PAS-2000 to the level of care evaluator

      - To submit the original, reviewed PAS-2000, with the admission documentation, to the provider of nursing facility services

   c. Responsibilities of the Level of Care Evaluator

      - To determine the client's need for and level of care, and to evaluate for the presence of mental illness/retardation

      - To return the original form, with the review determination, to the originating provider

      - To provide a computer printout of all PAS-2000 review results to county DHHR offices and to the BMS LTC Unit. The list includes the following:

        • Individual's name

        • SSN

        • Case number, if applicable

        • County

NURSING FACILITY SERVICES

C. ESTABLISHING MEDICAL NECESSITY, PHYSICIAN'S PROGRESS NOTES OR ORDERS

In certain circumstances, which may be beyond the control of the client or his representative, an individual may be admitted to a Medicaid certified nursing facility without the completion of a PAS-2000. 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-2000 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. This method may also be used when application is made and payment requested for a deceased individual when no valid PAS-2000 was completed.

This procedure is used only for backdating eligibility for nursing facility care when no PAS-2000 exists for the period for which payment of services is requested. The progress notes or orders cannot be used to change an existing PAS-2000 which does not certify need for nursing facility care. Eligibility may only be backdated up to 3 months prior to the month of application.

The Worker must record the reason for the use of the progress notes or orders in Case Comments.

INTERMEDIATE CARE FACILITY/MENTALLY RETARDED (ICF/MR)

17.54 INCOME

A. ELIGIBILITY

Non-excluded income for SSI-Related Medicaid is used for ICF/MR cases. See Chapter 10. The individual must have gross non-excluded income at or below 300% of the SSI payment level. When income exceeds this limit, the client may spenddown to the MNIL and become eligible. See Section 17.9.

B. POST-ELIGIBILITY

When the client has income at or below 300% of the SSI payment level or spends down to the MNIL level, the post-eligibility process is used to determine the client's contribution to his cost of care. See Section 17.9. Residents of an ICF/MR 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, or as a groundskeeper of an ICF/MR with more than 15 residents.