



## APPLE HEALTH (MEDICAID) MANUAL REVISION

<b>Revision #</b>	<b>018</b>
<b>Chapter / Section</b>	<b>Long-Term Care, General Eligibility for Long-Term Care</b>
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### Summary of Revision

Updated and revised the clarifying section of General eligibility for Long-Term care.

### Apple Health (Medicaid) Manual revision via track changes:

<http://washhca.prod.acquia-sites.com/free-or-low-cost-health-care/program-administration/general-eligibility-ltc>

[General eligibility for Long-Term Care](#)

## Clarifying Information

Special income level (SIL):

1. The ~~department~~ agency compares an individual's non-excluded income to the SIL to determine whether an individual is eligible for LTC services under the CN program. ~~Effective 4/1/2012~~ Individuals applying for HCB Waiver services authorized by Home and Community Services (HCS) can have income over the Medicaid SIL. (See WAC 182-515-1508).
2. The SIL is equal to 300% of the annually adjusted SSI Federal Benefit Rate (FBR).
3. The ~~department~~ agency does not allow income disregards when determining initial eligibility for CN services. ~~It reduces an individual's gross income only by the exclusions allowed~~ Income that is excluded by federal statute ~~as described in~~ under WAC 182-513-1340 is not counted.

### Income transfers:

1. The ~~department~~ agency considers any agreement between spouses to transfer or assign rights to future income to be invalid when determining an individual's income eligibility and participation in the cost of care.
2. The ~~department~~ agency considers such income available when comparing an individual's income to program ~~standards~~<sup>PR(1)</sup> and includes it when determining the participation amount whether or not the individual continues to receive it.
3. The ~~department~~ agency considers all of an individual's income to be available as described in WAC 182-513-1325 and WAC 182-513-1330, unless exceptional circumstances exist that include but are not limited to the following:
  - a When income is established as unavailable in an administrative hearing as described in chapter 182-526 WAC.
  - b When income that at one time belonged exclusively to an individual becomes property of the spouse in a community property state. An example of this is when a court divides a pension between spouses by use of a "qualified domestic relations order" (QDRO). Under a QDRO a court transfers a portion of the pension, which it considers a resource, and thereby transfers a portion of the income produced by the resource.
4. The ~~department~~ agency does not consider income generated by a transferred resource to be available. The income is a part of the resource, which is why the ~~department~~ agency evaluates the transfer of such an asset as the transfer of a resource as described in WAC 182-513-1363.

## LTC/Private Insurance:

### LTC Insurance and Third Party Resources

## Institutionalized SSI Clients:

If an SSI individual is admitted to a medical facility for a temporary period, SSI payments may continue for the first three months after admission.

1. As long as SSA determines an individual eligible to receive SSI, the individual does not participate in their cost of personal care.

## Involuntary Treatment Act (ITA):

Under the ITA, individuals of any age can be placed into certain institutions for mental diseases (IMD):

## Inpatient mental health treatment in Eastern or Western State Hospital:

Persons who are at least 21 and less than 65 years old who live in Eastern or Western State Hospital are not eligible for medical assistance (If an individual turns 21 in the facility while on medical assistance they can receive medical assistance until they discharge or turn 22, whichever comes first). Their medical needs are the responsibility of the hospital.

- As mandated by federal regulations, the department determines eligibility for medical assistance for all persons not disqualified by these age limits and requires participation in the cost of care as described in the program rules.

## Parental responsibility:

1. The financial responsibility of parents is limited to what they choose to contribute when their child is institutionalized under WAC 182-513-1320 including receiving HCB waiver services. receiving inpatient chemical dependency and/or mental health treatment that is expected to last for 90 days or more

- This rule remains in effect even if the expected length of treatment is shortened for any reason.

2. Children who are eligible for Medicaid under institutional rules while inpatient at Eastern or Western State Hospital remain continuously eligible for Medicaid

through the end of their one year certification upon discharge from the facility. See Clarifying Information- WAC 182-505-0210 and 182-504-0125 under Children's Medical Programs for instructions.

## Residency:

1. See **PR(3)** clarifying information on WAC 182-503-0520 for individuals not residing in an institution and 182-503-0525 for individuals residing in an institution

~~—The exempt status of the home for an individual receiving LTC services in a medical facility or alternate living facility allows for a broad definition of state residency.~~

2. If the individual or individual's representative expresses the individual's intent to return to the home, it is excluded when determining resources, even if the home is located in another state.

3. The expressed intent to return to a home that is in another state does not affect the individual's status as a Washington resident.

~~—Persons who come to Washington solely for medical care in a nursing facility may be considered residents of Washington. They can even maintain a residence in another state if they hope to return. However if a person is placed in a nursing facility by another state, the person is considered a resident of the state that placed them. The department will not deny or terminate Medicaid eligibility for a Washington resident who is absent temporarily and will return. For example, an individual who goes to a border facility for rehabilitation for 4 to 6 weeks and will return to Washington is not considered a resident of the border state and Washington will provide Medicaid benefits.~~

## Nursing facility (NF) - limitations on billing:

1. For **PR(4)** recipients active on medical coverage Medicaid the NF cannot can't bill an individual who applies for or receives institutional services for the days between admission and the date the facility first notified the department of the admission. This requirement is under RCW 74.42-056

2. For **applicants**, the ~~department~~ agency will back date nursing facility payment authorization up to ~~the institutional date~~ 3 months as long as the individual is otherwise eligible.

3. Recipients of non-MAGI medical ~~the Breast and Cervical Cancer or Healthcare for workers with disability (HWD)~~ programs must submit an application have

their eligibility redetermined for a determination of Medicaid eligibility using institutional rules if the client is in a medical institution 30 days or longer. Recipients of the non-MAGI medical ~~Breast and Cervical Cancer or HWD program~~ can have nursing facility paid as a short stay <sup>PR(5)</sup> for less than 30 day admissions only.

4. Recipients of MAGI medical do not need an award letter for the nursing facility to submit a claim. Instructions can be found in the nursing facility billing guide.
5. Nursing Home Services Prior Authorization is required under the State-funded nursing facility program.

## Medicare payment for NF cost of care: Medicare and Long term care

Home and Community Based (HCB) Waivers authorized by HCS

Home and Community Based (HCB) Waivers authorized by DDD

Hospice authorized by Health Care Authority

Roads to Community Living (RCL)

## Active MN Medicaid Individual Entering a Nursing Facility

Active <sup>PR(6)</sup> MN Medicaid individuals who have met spenddown and are placed in a nursing home see clarifying information for the medically needy program ~~would be allowed the following deductions to determine the amount of the individual's participation in the cost of care:~~

——— Allow the ~~MNII~~ <sup>PR(7)</sup> if the individual is at home the first day of the month he or she is admitted to the facility, or the appropriate personal needs allowance (PNA) based on the individual's living arrangements if not at home on the first day of the month. See institutional standards for current PNA amounts.

~~Individual's <sup>PR(8)</sup> monthly spenddown liability that has been met for each month through the certification period.~~

~~**Note:** The spenddown liability deduction is coded on the INST screen in ACES with notation in remarks. The determination of the MNIL/PNA is based on the information coded on the INST screen and DEM1 screen in ACES.~~

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~~All allowable deductions are found in WAC 182-515-1509 for HCS-CN Waivers, WAC 182-515-1514 for DDA-CN Waivers and WAC 182-513-1380 for residing in a medical institution.~~

~~The \$20.00 disregard used as a deduction for MN non-institutional spenddown is counted towards the individual's monthly nursing home participation in the post-eligibility process.~~

**Example:**

~~Single individual on Medicaid MN program with base period 1/01/06-3/06. Spenddown was met in February and case was certified effective 2/1/06. Individual has monthly income of \$848 per month. He enters the nursing home from home on 3/5/06.~~

~~His MN spenddown was computed as follows:~~

<del>\$848.00</del>	<del>monthly income</del>
<del>-\$20.00</del>	<del>=</del>
<del>-733.00</del>	<del>MNIL</del>
<del>=====</del>	<del>=</del>
<del>\$95.00</del>	<del>per month available for spenddown use as a deduction.</del>

~~Nursing Home Participation for 3/06 is computed as follows:~~

<del>\$848.00</del>	<del>monthly income</del>
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<u>-733.00</u>	<u>MNIL</u>
<u>-\$95.00</u>	<u>spenddown liability</u>
<u>=====</u>	<u>=</u>
<u>\$20.00</u>	<u>participation to the nursing facility.</u>

The spenddown base period ended in March. This deduction can only be used through the last month of the original MN base period.

For current MNIL standards, see LTC standard chart.

## MN Individual Entering Nursing Facility, Spenddown Has Not Been Met

- Nursing facility charges can be used as an incurred medical expense for individual's who have not met a spenddown within the base period. See instructions above for guidance once a spenddown has been met.

### Short Stay Less than 30 days in a Nursing Facility.

- For individuals who do not meet institutional status described in WAC 182-513-1320 but meet the functional eligibility requirement and are eligible for Medicaid.

### Inpatient Mental Health and DDA institutional admissions (ICF-ID and RHC)

- If it appears that an individual admitted to such a facility is eligible for medical benefits, facility staff determine if the individual is already approved for a particular program. Facility staff notify the DDA LTC specialty unit or CSD-IMD financial staff in writing of the individual's admission.
- If an individual is not already approved for medical benefits, facility staff assist the individual as needed to complete the application and sends it to the DDA LTC specialty unit or CSD-IMD financial staff. Facility staff make referrals as appropriate to the division of disability determination (DDDS) staff.
- When written notification of admission from the facility is received, document whether the individual intends to return home upon discharge.

- ~~—If the individual intends to return to the TANF H/H, family members are responsible for the individual's personal needs as grant is continued up to 180 days. See WAC 388-454-0015 If an individual who was expected to be inpatient for more than ninety days does not remain that long, increase the TANF/SFA grant to the full amount. This does not create an underpayment.~~
- ~~—If an SSI related client is admitted to such a facility and remains there for at least one full calendar month, make program changes in ACES to reflect the change to an institutional (L-track) coverage group and living arrangement. Determine eligibility for all program benefits as appropriate upon the individual's discharge from the facility.~~
- ~~—If the individual is not discharged and remains eligible for Medicaid, complete an eligibility review (ER) every twelve months. Contact facility staff for information to complete the ER.~~
- ~~—Follow necessary supplemental accommodation (NSA) procedures.~~

## Worker Responsibilities

1. See Application processes for LTC services
2. Follow rules for Washington Apple Health (WAH) Eligibility requirements:
  1. Chapter 182-503 WAC describes:
    1. How to Apply
    2. Who can apply
    3. Interview requirements
    4. Verification requirements
    5. Application processing times
    6. When coverage begins
    7. Application denials and withdrawals
    8. Exceptions to rule
    9. Rights and responsibilities
    10. Limited English proficient (LEP) services



11. Equal Access Services
12. General eligibility requirements
13. Program Summary
14. Social Security number requirements
15. Residency requirements-Persons who are not residing in an institution
16. Residency requirements for an institutionalized person
17. Citizenship and alien status- Definitions
18. Assignment of rights and cooperation
19. Age requirements for medical programs based on modified adjusted gross income (MAGI)

2. Chapter 182-504 WAC describes:

1. Retroactive certification period
2. Certification periods for categorically needy (CN) programs
3. Certification periods for non-institutional medically needy (MN) programs
4. Medicare Savings Programs certification periods
5. Renewals
6. Changes that must be reported
7. When to report changes
8. Effective dates of changes
9. Effect of reported changes
10. Continued coverage pending an appeal
11. Monthly income standards based on the federal poverty level (FPL)

3. Follow rules in Chapter 182-506 WAC regarding assistance units

4. Follow rules in Chapter 182-507 WAC for state funded LTC for non citizens and AEM
5. Follow rules in Chapter 182-508 WAC for Medicare Care Services (MCS) state funded medical
6. Follow rules in Chapter 182-510 for SSI medical
7. Follow rules in Chapter 182-511 for SSI related Healthcare for Workers with Disabilities (HWD).
8. Follow rules in Chapter 182-512 for SSI related medical
9. For a nursing facility or state funded residential individual whose eligibility is established under the A01 program, waive the sequential evaluation process (SEP) for an individual who is eligible to receive ADS services in a nursing facility or state funded residential, refer to the CSO disability specialist for a determination of ABD cash if potentially eligible for ABD cash. If not eligible for ABD cash, because of the duration requirement, open on A01 MCS which includes a referral for Housing Essential Needs (HEN).
10. For an individual with a potential long-term disability who is not eligible for ABD cash, submit a request to the Division of Disability Determination Services (DDDS).
11. If a person is ineligible because of excess income or resources, or does not meet functional eligibility requirements, notify the individual of the reasons why the application is denied. Determine eligibility for non-institutional medical assistance as if the individual were living in their own home.
12. If notice is received that an individual no longer needs care provided in a medical facility, redetermine eligibility for other medical programs. CN Medicaid is continued during the redetermination process.
13. If an individual who is denied services for not meeting functional requirements requests an administrative hearing, notify the SW. The staff person who completed the assessment represents the ~~department~~ agency at the hearing, unless someone else is designated for that responsibility.
14. A Individuals who have insurance must complete 14-194 Medical Coverage Information form ~~must be completed if an individual has insurance~~ including LTC insurance. ~~For offices in the DMS system, t~~The Coordination of Benefits (COB) unit at HCA will receive ~~an automatic assignment of~~ the 14-194 Medical Coverage Information form. The COB unit enters information from the Medical Coverage

Form into their system. The information is interfaced with ACES and the TPL screens are auto populated.

15. Nursing facilities will be responsible for collecting payments from TPL carriers or obtaining a denial of benefits before ~~DSHS~~ agency can pay the facilities. The ~~department~~ agency will continue to assign participation, which the nursing facility may collect until the TPL party begins making payments. See Long-term care insurance and third party resources.

16. Admissions under 30 days into a medical facility is considered a short stay.

## ACES Procedures

Long Term Care and Waiver Services—Interview

Long Term Care, Alternate Care and Waiver Services

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