Revision Date:
06/01/2021

Background:
The Social Security Act, Section 1915(c) permits states to request waivers to provide certain services to people at home or in the community as a cost neutral alternative to institutionalized health care, provided such non-institutionalized services meet the health and safety needs of the customer. The goal is that the customer will experience an enhanced and enriched quality of life if allowed to return home or to the community.

Purpose:
This section provides an overview of the Home and Community-Based Services (HCBS) Waiver Programs and has been updated to include clarifications issued in All County Welfare Directors Letters (ACWDLs) 18-19, 20-15 and Medi-Cal Eligibility Division Information Letter (MEDIL) 21-07.

Policy:
05.18.01A Home and Community-Based Services (HCBS) Waivers
There are currently five HCBS Waivers in effect in San Diego:

- Home and Community-Based Services for the Developmentally Disabled (HCBS-DD) Waiver-DDS Waiver
- Home and Community-Based Alternatives (HCBA) Waiver – Formerly Nursing Facility/Acute Hospital (NF/AH) Waiver and In-Home Operations (IHO) Waiver
- Multipurpose Senior Services Program (MSSP) Waiver
- Assisted Living Waiver (ALW)
- Acquired Immune Deficiency Syndrome (AIDS) Waiver

The first four waivers allow for special Medi-Cal rules (also known as Institutional Deeming) when determining Medi-Cal eligibility for customers who are eligible to these waivers. The AIDS Waiver follows regular Medi-Cal rules. A customer who has a Share of Cost (SOC) or is not property eligible for Medi-Cal under regular income/property rules may benefit from these waivers.

A customer may initiate the HCBS Waiver process by:

- Applying for Medi-Cal
- Contacting a waiver administrator
- Contacting a Care-Coordinating Agency (CCA) that works with the waiver administrator

The request for HCBS can be made verbally, in writing, or by answering “yes” to the question on the Medi-Cal application. For waivers that allow special Medi-Cal rules, the agency responsible for the waiver will refer the customer for a Medi-Cal determination if they are not already receiving Medi-Cal with no SOC and are eligible or potentially eligible for a particular waiver.

05.18.01B HCBS Waivers and Spousal Impoverishment (SI) Provisions
SI Provisions allow the allocation of income and resources from the institutional spouse to the community spouse or other dependent family members. Effective January 1, 2014, the Affordable Care Act (ACA) broadened the definition of an institutionalized spouse to include HCBS recipients and those who have requested HCBS, who (generally) reside in the home or in the community.

With this change, SI provisions are an eligibility step rather than being included in the institutional deeming process and must be used to determine Medi-Cal when a customer requests an HCBS waiver or HCBS waiver services rather than waiting for the waiver to be approved.

Use the manual 14-152A HHSA Budget Steps for HCBS Spousal Impoverishment (01/2014) worksheet when determining eligibility from 01/2014-11/2020 and the 14-152 HHSA Budget Steps for HCBS Spousal Impoverishment (12/2020) worksheet when determining eligibility from 12/2020 and forward for HCBS SI to determine the spousal and dependent family member allocations as part of the eligibility process.

Note: HCBS Waiver and Long-Term Care (LTC) benefits and services are provided to beneficiaries under the Modified Adjusted Gross Income (MAGI) coverage groups, including the Optional Targeted Low Income Children's Program (OTLICP), without time limits and no change in aid code if the customer meets eligibility criteria under MAGI. The spousal and dependent family member allocation rules **do not** apply to MAGI.

Who SI Applies To:

SI provisions apply to married customers and Registered Domestic Partners (RDPs) who on or after January 1, 2014, are/were:

- New Medi-Cal customers who requested HCBS waiver services, in-home assistance, or In-Home Supportive Services (IHSS)
- In an HCBS waiver (in institutional deeming aid codes 1X, 1Y, 6V, 6W, 6X, or 6Y)
- On a HCBS waiver wait list and are receiving Medi-Cal or requesting Medi-Cal
- Requesting or receiving HCBS waivers or program services, including IHSS, but were denied or discontinued due to excess property
- Receiving HCBS waiver or program services, including IHSS and have a Medi-Cal SOC
- Enrolled in In-Home Supportive Services/Community First Choice Option (IHSS-CFCO) programs (2K aid code)
- Requiring a Nursing Facility Level of Care (NFLOC)

The request for HCBS or IHSS can be made verbally, in writing, or by answering "yes" to the question on the Medi-Cal application. Customers requesting IHSS do not need to say they are requesting IHSS-CFCO. Any IHSS request is adequate to initiate a referral to IHSS, however, the IHSS-CFCO is the **only** program that provides the appropriate level of care to initiate the application of the SI provisions.

When to Apply SI Provisions/Applicable Application Date

SI provisions are applied the first month when **both** of the following exist:

- The request for either HCBS or IHSS has been made
- The customer meets the NFLOC documented through the MC 604 MDV Doctor's Verification form or through a Needs Assessment issued by the HCBS waiver or program

See Desk Aid 94 for examples on establishing the applicable application date for SI Provisions and SI applied retroactively.

Once determined eligible using SI provisions the HCBS spouse remains eligible, unless any of the following occur:

- A change in circumstance (for example: Death, moved out of state, dissolution of marriage, or the Continuous Period of Institutionalization ends)
- Until the request for HCBS is denied for not meeting clinical standard for the waiver
- The customer is not identified as IHSS-CFCO recipient

Note: This will require communication between the IHSS Social Worker or the Waiver Administrator/CCA and Human Services Specialist (HSS). A 10-day notice is required for negative action.

Refer to Processing Guide 25 when an HCBS Waiver is initiated by other than the waiver administrator/CCA and no Needs Assessment for the waiver has been completed.

<u>MC 604 MDV Doctor's Verification Form/Needs Assessment</u>

The Doctor's Verification form and the Needs Assessment serve different functions and are not interchangeable. Both may be required for a customer requesting in-home care depending on the timing of the request for services and their individual circumstances.

A Needs Assessment establishes that the customer meets the NFLOC for at least 30 consecutive days and may state the HCBS waiver program for which the customer is approved. When the Needs Assessment has been completed by IHSS or an HCBS coordinator before applying for Medi-Cal, Spousal Impoverishment (SI) provisions apply.

Any request for HCBS initiates the Doctor's Verification Form process unless there already has been a Needs Assessment for a waiver program or IHSS-CFCO completed for the customer, including if the customer is on a waiting list.

A Doctor's Verification form MC 604 MDV is required to be signed by the customer. This form:

- Authorizes the customer's doctor to release information to the County
- Establishes if the customer meets the NFLOC for at least 30 consecutive days in the absence of HCBS
- Begins the Continuous Period of Institutionalization

In the absence of a waiver Needs Assessment, SI provisions are **<u>not</u>** applied until the Doctor's Verification form MC604 MDV is completed and returned by the customer's doctor. When the completed form is received, apply SI provisions retroactively on or after January 1, 2014, if the date of NFLOC and the date of the request for IHSS/HCBS waiver program of services occurred in the past.

A Doctor's verification form is **<u>not</u>** required for customers who are active in the IHSS-CFCO 2K aid code. See Processing Guide 25 for the Doctor's Verification Form process.

05.18.01C Continuous Period of Institutionalization

The Continuous Period of Institutionalization is the:

- Timeframe beginning the day the request for either HCBS or IHSS has been made, **and** the customer meets a NFLOC documented through the MC 604 MDV Doctor's Verification form or through a Needs Assessment issued by the HCBS waiver program
- Period that determines the length of time the institutionalized spouse is eligible to SI provisions before being placed on a waiting list or participating in an HCBS waiver

The SI provisions will remain only if the application for HCBS is completed prior to the Continuous Period of Institutionalization ending. If an approved request for HCBS results in the customer's placement on a waiting list, the SI provisions continue to apply.

See Desk Aid 95 for an example of the Continuous Period of Institutionalization.

The Continuous Period of Institutionalization period ends when:

- The request for HCBS is denied
- It is determined the customer is not an IHSS-CFCO recipient (2K aid code)
- The customer fails to follow through and complete the HCBS application process
- The HCBS spouse or institutionalized spouse does not receive HCBS waiver or program services or inpatient care in a medical institution or nursing facility for a full calendar month

Follow the steps in Processing Guide 25 to refer and confirm that the application for HCBS has been completed before the end of the Continuous Period of Institutionalization.

Note: If the community spouse also requests HCBS, there is no longer a community spouse. Spouses remain in separate Medi-Cal Family Budget Units (MFBUs) and SI provisions will not apply in this scenario. However, the division of community property and income rules may apply.

05.18.01D Retroactive Application of SI Provisions for HCBS

The retroactive evaluation of SI provisions for HCBS must be processed **before** current eligibility is established because the Community Spouse Resource Allowance (CSRA) applies once in the initial month of eligibility. Retroactive SI eligibility must be confirmed prior to rescinding a case.

Apply the SI provisions retroactively under any of the following circumstances to cases where there would have been an eligible HCBS spouse on or after January 1, 2014 when:

- The County becomes aware of a case that meets these standards
- The customer is participating in the IHSS-CFCO program in the 2K aid code* with a SOC
- There is a new application or annual redetermination
- A fair hearing is requested
- The customer requests a retroactive redetermination
- The customer was denied/discontinued due to excess income or property based on the community spouse residing in their own home (not institutionalized)

*Aid code 2K was implemented in September 2014. If the customer was IHSS-CFCO eligible between January 1, 2014, and September 1, 2014, please elevate to Medi-Cal program for assistance in verifying the IHSS-CFCO level of care.

Use the manual 14-152A HHSA Budget Steps for HCBS Spousal Impoverishment (01/2014) worksheet when determining eligibility from 01/2014-11/2020 and the 14-152 HHSA Budget Steps for HCBS Spousal Impoverishment (12/2020) worksheet when determining eligibility from 12/2020 and forward for HCBS SI to determine the spousal and dependent family member allocations as part of the eligibility process. Refer to MPG 09.13 for CSRA guidelines.

See Processing Guide 25 for the retroactive SI for HCBS evaluation procedures. Desk Aids 94, and 95 have been created to provide case examples.

05.18.01E Retroactive Beneficiary Reimbursement Process (BRP)

A customer may request reimbursement of out-of-pocket Medi-Cal claims or services provided by an IHSS enrolled provider under the BRP. See MPG 04.02.10J for the BRP (also known as the Conlan process).

See Processing Guide 25 for scenarios the HSS may encounter when processing retroactive eligibility under SI for IHSS-CFCO, and the appropriate referral process.

05.18.01F Manual Budget Evaluation

A manual budget evaluation (14-152A HHSA Budget Steps for HCBS Spousal Impoverishment [01/2014] and/or 14-152 HHSA Budget Steps for HCBS Spousal Impoverishment [12/2020] worksheet) is required when SI provisions apply and the customer requests HCBS. Under SI provisions for HCBS:

- There is no $35 LTC needs allowance
- Spouses are in separate MFBUs even though the HCBS spouse may be in the home, not in an institution
- Use all applicable Non-MAGI program income deductions and disregards
- The Federal Poverty Level (FPL) and Maintenance Need limit for one person is used
- All applicable spousal and dependent family member income allocations apply

05.18.01G HCBS Waiver Aid-Codes

Waiver aid codes are **not** required to be present in the Medi-Cal Eligibility Data System (MEDS) for customers eligible for a zero SOC under SI provisions or any other Medi-Cal program if they meet HCBS waiver requirements and pass the Needs Assessment. Waiver aid codes will still appear in MEDS for customers who require institutional deeming to be eligible for waiver services.

HCBS Waiver program aid codes are considered voluntary managed care enrollees. The enrollment process is done through Health Care Options (HCO). Medi-Cal beneficiaries with a zero SOC in a mandatory managed care plan aid code may choose to disenroll from managed care by completing HCO-02 Medi-Cal Waiver Program Exemption Certification. The medical providers usually initiate this form.

05.18.01H Annual Redetermination

Follow the annual redetermination process outlined in MPG 04.15.01. Only information about the HCBS waiver customer is required. The HCBS spouse/Authorized Representative (AR), community spouse, or waiver administrator/CCA need only confirm continued HCBS waiver participation, if the period of HCBS participation or institutionalization continues. Once eligibility under SI provisions has

been established, do not recalculate the CSRA, verify the property of the community spouse, or verify the NFLOC at the annual redetermination.

05.18.01I Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
EPSDT is a Medi-Cal benefit for customers under 21 years old which requires that States provide medically necessary screening, vision, hearing, and dental services to Medi-Cal beneficiaries. The program may provide licensed skilled nursing in the home. Therefore, Medi-Cal eligible children who are institutionalized will now be able to return home from institutionalization and those who are home can remain there when receiving additional medical services under the EPSDT program if certain criteria, including cost effectiveness, are met.

05.18.01J Supplemental Security Income (SSI) Personal Needs Allowance (PNA)
Effective June 1, 1990, federal law began allowing a former institutionalized SSI child the same PNA as an institutionalized SSI child if the noninstitutionalized child is in a home and a community-based waiver applies. The Social Security Administration (SSA) must confirm that a child is in a waiver program before the PNA can begin or continue. Staff **must request an authorization form** from the child's parent or guardian before providing verification to SSA that the child is in a waiver program. The information may be requested at the time the waiver coverage begins and then at the SSA redetermination.

The Medi-Cal Waiver Information and Authorization form DHCS 7071 was developed to secure parental consent and allow to release this information to SSA. In addition, staff should be aware that in some cases, when the waiver customer begins receiving the PNA, MEDS will convert the waiver aid code to aid code 60. If this occurs and the waiver person is still living in the home and is ineligible for a regular SSI payment, contact the Department of Health Care Services (DHCS) to have the aid code corrected.

Procedures:
Procedures for the HCBS Waiver programs are listed in Processing Guide 25.

Program Impacts:
Forms: 14-152A HHSA Budget Steps for HCBS Spousal Impoverishment (01/2014) and 14-152 HHSA Budget Steps for HCBS Spousal Impoverishment (12/2020) worksheet and the 14-153 Referral to IHSS and HCBS Waiver Agencies have been added to Eligibility Forms Library (EFL).

Automation: SI approvals for HCBS in the California Work Opportunity and Responsibility to Kids Information Network (CalWIN) require a manual override. Refer to the Business Environment Design Strategies (BEnDS) 49130 in Eligibility Essentials for CalWIN entries.

Special Indicator "MC HCBS Spousal Impoverishment" has been added to identify these cases.

References:
MEM PROC 19D
MEPM Letter No. 307
ACWDL 87-77, 90-01, 90-03, 91-84, 03-22, 03-31, 03-31E, 12-36, 17-15, 17-25, 18-19, 20-15
MEDIL 14-38, 18-10, 21-07

Sunset Date:
This policy will be reviewed for continuance by 06/30/2024.

Approval for Release:

Rick Wanne, Director
Self-Sufficiency Services

Revision Date:
06/01/2021

Background:
The Department of Health Care Services (DHCS) applied for and received federal approval from the Federal Centers for Medicare and Medicaid Services for the Home and Community-Based Services for the Developmentally Disabled (HCBS-DD) Waiver. The Department of Developmental Services (DDS) Waiver is a subset of the HCBS-DD Waiver.

Purpose:
This section will provide guidance for processing the DDS Waiver portion of the HCBS-DD Waiver. This section is being updated to include clarifications contained in All County Welfare Directors Letter (ACWDL) 18-19.

Policy:
The DDS Waiver is for customers (no age limit) diagnosed as developmentally disabled prior to their 18th birthday. These customers must live at home and meet the admission criteria for an Intermediate Care Facility for the Developmentally Disabled (ICF-DD) as defined in the California Health and Safety Code.

The San Diego Regional Center (SDRC) determines if the customer/customer's family meets the criteria for the DDS Waiver program. The waiver provides developmentally disabled customers, who are Regional Center consumers, the ability to receive care at home instead of care provided in an ICF-DD or a State Developmental Center.

Procedure:
05.18.02A Referring Agency
SDRC is responsible for the DDS Waiver referrals. SDRC determines whether the customer is eligible to participate in the waiver program by reviewing the customer's medical, social, and developmental care needs. When appropriate, the SDRC will refer the customer to Medi-Cal for an eligibility determination or redetermination via the DDS Waiver Referral form DHCS 7096. If no responsible relative is available to act on behalf of the customer, or the responsible relative does not wish to apply for the customer, the SDRC representative may do so.

Staff may **not** share ongoing eligibility information with SDRC without a signed Authorization for Release of Information.

The Regional Center for San Diego and Imperial Counties is located at:

4355 Ruffin Road Ste. 205 858-576-2996
San Diego, CA 92123-1648 858 576-2873 Fax

05.18.02B Eligibility Determination
Refer to Processing Guide 25 for the steps to take when processing an application with a DDS Waiver referral.

05.18.02C Beginning Date of Eligibility and Retroactive Coverage

The effective date of eligibility for a customer using the special rules (also known as Institutional Deeming) under the DDS Waiver is the date the following two requirements are met:

- The referring agency determines that it is medically appropriate for the Waiver customer to be in the Waiver. Normally, this is the date on the waiver referral
- The Human Services Specialist (HSS) determines that the Waiver customer meets the Medi-Cal eligibility requirements under that Waiver

If a customer requests retroactive Medi-Cal coverage, regular Medi-Cal rules apply. If the customer requests retroactive eligibility also be evaluated using the special rules under the Waiver, contact the representative of the referring agency to inquire whether the Waiver also covers the retroactive period. The response must be narrated in case comments. In lieu of the customer completing the retroactive section of the Statement of Facts (SOF), the original referral form may include a cover letter requesting retroactive Medi-Cal.

05.18.02D Institutional Deeming/Special Rules

When a DDS referral is received and it's determined that the customer will be property ineligible or has a share of cost (SOC) using regular Medi-Cal rules, the special rules below apply:

- The customer is treated as if they were institutionalized for purposes of the treatment of income and resources. When the customer is a child, parental income and resources are not considered even though the child lives in the home
- A second vehicle is exempt if the vehicle has been modified to accommodate the physical handicap(s) or medical needs of the customer. Verification is by the physician's written statement of necessity
- The customer is in their own Medi-Cal Family Budget Unit (MFBU). If other family members wish to be aided, the customer is treated like those on public assistance (PA). The waiver customer may be used to link other family members although the customer is not in the family's MFBU
- The DDS customer must be eligible for full scope benefits with or without a SOC
  Note: A customer residing in a nursing home under the limited state-only aid code of 53, in another limited-scope aid code, or a customer (age 26 or older) who does not have satisfactory immigration status (SIS) is not eligible.
- Use the most beneficial full-scope Medi-Cal program to determine eligibility that is applicable to the customer, for example, Pickle, the Aged and Disabled (A&D) program, or the Medically Needy (MN) program. Eligibility is based on the customer's own income and resources, including amounts remaining after Spousal Impoverishment (SI) provisions are applied
- A disability determination is not required unless:
  - Eligibility is based on a Medi-Cal program requiring that the customer be disabled
  - The customer has no other basis for linkage
  - There would be an advantage if the customer were disabled, for example, income deductions available only to the disabled. If this is a child, the determination of disability may be advantageous in the future when they become an adult.

Note: The Institutional Deeming/Special Rules **do not** apply to the Modified Adjusted Gross Income (MAGI) Medi-Cal program.

05.18.02E Aid Codes
The following aid codes are used for DDS Waiver eligible cases when Institutional Deeming/Special Rules are applied:
- 6V- DD Waiver Zero SOC
- 6W- DD Waiver SOC

05.18.02G Notice of Action (NOA)
Use appropriate approval, denial, or discontinuance NOA:
- MC 341 DDS Waiver approval NOA
- MC 342 DDS Waiver denial/discontinuance NOA

Program Impacts:
Automation
The *Collect Individual Attributes Detail* window in the California Work Opportunity and Responsibility to Kids Information Network (CalWIN) must be completed to ensure eligibility is determined under the DDS Waiver.

Refer to the Business Environment Design Strategies (BEnDS) 49130 in Eligibility Essentials for CalWIN entries when applying SI.

Forms and Document Capture
Image all appropriate forms into the case record.

References:
MEPM 19D
ACWDL 17-15, 17-25, 18-19
MEDIL 14-38

Sunset Date:
This policy will be reviewed for continuance by 06/30/2024.

Approval for Release:

Rick Wanne, Director
Self-Sufficiency Services

Revision Date:
06/01/2021

Background:
The Department of Health Care Services (DHCS) applied for and received federal approval from the Federal Centers for Medicare and Medicaid Services (CMS) for the Home and Community-Based Alternatives (HCBA) Waiver.

Purpose:
To provide guidelines for the processing of the HCBA Waiver. This section is being updated to include clarifications contained in All County Welfare Directors Letter (ACWDL) 18-19.

Policy:
The DHCS HCBA section determines if the customer (no age limit) meets the criteria for the HCBA Waiver. The HCBA Waiver was limited to people who require Nursing Facility level of Care (NFLOC) or sub-acute services for at least 90 consecutive days, but who wish to live at home or in the community. Effective January 1, 2014, customers who require NFLOC or sub-acute services for at least 30 consecutive days are eligible to receive the waiver.

HCBA waiver services provided include but are not limited to: Case management, skilled nursing, home health aides, language services, speech, hearing, family training and therapy, physical therapy, and adaptations to the home. Inpatient status before enrollment of waiver services is not required.

Procedure:
05.18.03A Referring Agency
The referring agency for the Medi-Cal HCBA Waiver is the DHCS HCBA Section. The purpose of HCBA is to ensure that necessary, appropriate, and quality medical and nursing services are authorized and provided in the home setting. HCBA staff facilitate the proposal documentation and development between each waiver participant and provider. This process allows for review of all issues related to the level of care, evaluation of durable medical equipment, medication, nursing hours, cost effectiveness and verification by HCBA staff that the home environment is appropriate to meet the health and safety needs of the customer. Final approvals of individual waiver requests are subject to review by a medical physician and other staff.

When the medical assessment is completed, the Human Services Specialist (HSS) receives a copy of the Medi-Cal HCBA Waiver Medi-Cal Eligibility Notice, from the Medi-Cal Program Specialist.

Some customers receiving benefits under the Department of Developmental Services (DDS) Waiver may be referred by DHCS HCBA to change to the HCBA Waiver due to a better match for services. The HSS receives a copy of the Medi-Cal HCBA Waiver Eligibility Notice from the Medi-Cal Program Specialist. The HSS must change the aid code to the appropriate Medi-Cal HCBA Waiver aid code, see 05.18.03C to determine the beginning date of eligibility.

Note: Customers under the age of 21 must be able to access a waiver service which is not covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Refer to 05.18.01 for EPSDT information.

05.18.03B Eligibility Determination

Refer to Processing Guide 25 for the steps to take when processing an application with an HCBA Waiver referral.

05.18.03C Beginning Date of Eligibility and Retroactive Coverage

The effective date of eligibility for a customer using the special rules under the HCBA Waiver is the date the following requirements are met:

- The referring agency determines that it is medically appropriate for the Waiver customer to be in the Waiver. Normally, this is the date on the HCBA Waiver referral, or
- The person requests both Medi-Cal and Home and Community Based Services (HCBS) for the Waiver customer and the completed Doctor's Verification form has been received, and
- The HSS determines that the Waiver customer meets the Medi-Cal eligibility requirements under that Waiver.

If a customer requests retroactive Medi-Cal coverage, regular Medi-Cal rules apply. If the customer requests retroactive eligibility also be evaluated using the special rules under the Waiver, contact the representative of the referring agency to inquire if the Waiver also covers the retroactive period. The response must be narrated in case comments. In lieu of completing the retroactive section of the Statement of Facts (SOF), the original referral form may include a cover letter requesting retroactive Medi-Cal.

05.18.03D Institutional Deeming/Special Rules

When an HCBA referral is received and it's determined that the customer will be property ineligible or has a Share of Cost (SOC) using regular Medi-Cal rules, the special rules below apply:

- The customer is treated as if they were institutionalized for purposes of the treatment of income and resources. If the customer is a child, parental income and resources are not considered even though the child lives in the home
- A second vehicle is exempt if the vehicle has been modified to accommodate the physical handicap(s) or medical needs of the customer. Verification is by the physician's written statement of necessity
- The customer is in their own Medi-Cal Family Budget Unit (MFBU). If other family members wish to be aided, the customer is treated like those on public assistance (PA). The waiver customer may be used to link other family members although the customer is not in the family's MFBU
- The HCBA customer must be eligible for full scope benefits with or without a SOC
  Note: A customer residing in a nursing home under the limited state-only aid code of 53, in another limited-scope aid code, or a customer (age 26 or older) who does not have satisfactory immigration status (SIS) is not eligible
- Use the most beneficial full-scope Medi-Cal program to determine eligibility that is applicable to the customer, for example, Pickle, the Aged and Disabled (A&D) program, or the Medically Needy (MN) program. Eligibility is based on the customer's own income and resources, including amounts remaining after Spousal Impoverishment (SI) provisions are applied
- A disability determination is not required unless:
  - Eligibility is based on a Medi-Cal program requiring that the customer be disabled
  - The customer has no other basis for linkage

- There would be an advantage if the customer were disabled, for example, income deductions available only to the disabled. If this is a child, the determination of disability may be advantageous in the future when they become an adult

Note: The Institutional Deeming/Special Rules **do not** apply to the Modified Adjusted Gross Income (MAGI) Medi-Cal program.

05.18.03E Aid Codes

The following aid codes are used for Medi-Cal HCBA Waiver eligible cases when Institutional Deeming/Special Rules are applied:

- 6X – Medi-Cal HCBA Waiver Zero SOC
- 6Y – Medi-Cal HCBA Waiver SOC

05.18.03F Notice of Action (NOA)

Use appropriate approval, denial, or discontinuance NOA:

- MC 343 HCBA Waiver approval NOA
- MC 344 HCBA Waiver denial/discontinuance NOA

Program Impacts:

Automation

The *Collect Individual Attributes Detail* window in the California Work Opportunity and Responsibility to Kids Information Network (CalWIN) must be completed to ensure eligibility is determined under the HCBA Waiver.

Refer to the Business Environment Design Strategies (BEnDS) 49130 in Eligibility Essentials for CalWIN entries when applying SI provisions.

Forms and Document Capture

Image all appropriate forms into the case record.

References:

ACWDL 03-31, 03-31E, 17-25, 18-19
MEDIL 14-38
MEPM 19D

Sunset Date:

This policy will be reviewed for continuance by 06/30/2024.

Approval for Release:

Rick Wanne, Director
Self-Sufficiency Services

Revision Date:
06/01/2021

Background:
The Department of Health Care Services (DHCS) applied for and received federal approval from the Federal Centers for Medicare and Medicaid Services (CMS) for the Multipurpose Senior Services Program (MSSP) Waiver.

Purpose:
This section provides guidelines for processing of the MSSP Waiver. This section is being updated to include clarifications contained in All County Welfare Directors Letter (ACWDL) 18-19.

Policy:
The MSSP Waiver Program is limited to customers who are:
- Aged (age 65 or older)
- Receiving full-scope Medi-Cal
- Certifiable for placement in a nursing facility
- Living within Aging and Independent Services (AIS) service area
- Able to be served within the program's cost limitations
- Eligible for care management services

Many of the waiver participants live at home and were on Medi-Cal before being accepted into the Waiver. Services include case management, adult social day care, housing assistance, protective services, personal care, respite care, transportation, meal, and special communication services.

Procedure:
05.18.04A Referring Agency
The California Department of Aging (CDA) is the referring agency. AIS is the local administrator in San Diego County. The assessment for the MSSP waiver is completed before the customer is referred to the County. The MSSP customer is referred using form MC 364. Effective January 1, 2014, the MSSP Waiver process may be initiated by the customer, spouse, or Authorized Representative (AR) when applying for Medi-Cal. Refer to Processing Guide 25 when a waiver is requested by other than CDA.

05.18.04B Eligibility Determination
Refer to Processing Guide 25 for the steps to take when processing an application with a MSSP Waiver referral.

05.18.04C Beginning Date of Eligibility and Retroactive Coverage
The effective date of eligibility for a customer using the special rules (also known as Institutional Deeming) under the MSSP Waiver is the date the following two requirements are met:
- The referring agency determines that the customer is medically eligible to the Waiver. Normally, this is the date on the MSSP Waiver referral
- The Human Services Specialist (HSS) determines that the Waiver customer meets the Medi-Cal eligibility requirements under that Waiver

If a customer requests retroactive Medi-Cal coverage, regular Medi-Cal rules apply. If the customer requests retroactive eligibility also be evaluated using the special rules under the Waiver, contact the representative of the referring agency to inquire if the Waiver also covers the retroactive period. The response must be narrated in case comments. In lieu of completing the retroactive section of the Statement of Facts (SOF), the original referral form may include a cover letter requesting retroactive Medi-Cal.

05.18.04D Institutional Deeming/Special Rules

When an MSSP referral is received and it's determined that the customer will be property ineligible using regular Medi-Cal rules, the waiver allows for institutional deeming, the special rules below apply:

- A second vehicle is exempt if the vehicle has been modified to accommodate the physical handicap(s) or medical needs of the customer. Verification is by the physician's written statement of necessity
- The MSSP customer is in their own Medi-Cal Family Budget Unit (MFBU). If other family members wish to be aided, the customer is treated like those on public assistance. The customer may be used to link other family members although the customer is not in the family's MFBU
- The MSSP customer must be eligible for full scope benefits with or without a Share of Cost (SOC)
  Note: A customer residing in a nursing home under the limited state-only aid code of 53, in another limited-scope aid code, or does not have satisfactory immigration status (SIS) is not eligible
- Use the most beneficial full-scope Medi-Cal program to determine eligibility that is applicable to the customer, for example, Pickle, the Aged and Disabled (A&D) program, or the Medically Needy (MN) program. Eligibility is based on the customer's own income and resources, including amounts remaining after Spousal Impoverishment (SI) provisions are applied

Note: The Institutional Deeming/Special Rules **do not** apply to the Modified Adjusted Gross Income (MAGI) Medi-Cal program.

05.18.04E Aid Codes

The following aid codes are used for Medi-Cal MSSP Waiver eligible cases when Institutional Deeming/Special Rules are applied:

- 1X – MSSP Waiver Zero SOC
- 1Y – MSSP Waiver SOC

05.18.04F Notice of Action (NOA)

Use appropriate approval, denial, or discontinuance NOA:

- MC 365 MSSP Waiver approval NOA
- MC 366 MSSP Waiver denial/discontinuance NOA

Program Impacts:

Automation

The *Collect Individual Attributes Detail* window in in the California Work Opportunity and Responsibility to Kids Information Network (CalWIN) must be completed to ensure eligibility is determined under the MSSP Waiver.

Refer to the Business Environment Design Strategies (BEnDS) 49130 in Eligibility Essentials for CalWIN entries when applying SI.

Forms and Document Capture
Image all appropriate forms into the case record.

References:
ACWDLs 03-22, 17-25, 18-19
MEDIL 14-38,
MEPM Article 19D

Sunset Date:
This policy will be reviewed for continuance by 06/30/2024.

Approval for Release:

Rick Wanne, Director
Self-Sufficiency Services

Revision Date:
06/01/2021

Background:
The Department of Health Care Services (DHCS) applied for and received federal approval from the Federal Centers for Medicare and Medicaid Services (CMS) for the Assisted Living Waiver (ALW).

Purpose:
This section provides policy guidelines for processing the ALW. This section is being updated to include changes contained in All County Welfare Directors Letter (ACWDL) 18-19.

Policy:
The ALW provides a viable alternative to long-term care for certain customers because it allows customers to live in the community while receiving many of the services that would be available in long-term care. The ALW provides the assisted living benefits in two settings:
- Residential care facilities for the elderly (RCFEs)
- Publicly funded senior and/or disabled housing (PSH)

ALW benefits include:
- Assisted living benefit as rendered by the RCFE setting
- Assisted living benefit as rendered by a Medi-Cal licensed and certified home health agency in the PSH setting
- Care coordination

Medi-Cal eligible customers residing in an ALW provider site and enrolled into the ALW have the following characteristics:
- Have full-scope Medi-Cal eligibility without a Medi-Cal share of cost (SOC)
- Determined to have enough disposable income by DHCS
- Are aged or disabled (Note: Blind customers for the ALW will need to be determined disabled to be part of this waiver)
- Meet the Nursing Facility (A or B) Level of Care (NFLOC)
- Are at least 21 years of age

Customers ineligible for the ALW are those who:
- Reside in a residential care facility under state only aid code 53
- Are in a limited scope aid code due to failure to comply with Deficit Reduction Act (DRA) citizenship and identity regulations
- Are persons (age 26 or older) who do not have Satisfactory Immigration Status (SIS)
- Are enrolled in another Home and Community-Based Services (HCBS) waiver

Note: The ALW is available in San Diego and there are ALW provider facilities in San Diego. For a list of ALW facilities, go to: https://www.dhcs.ca.gov/services/ltc/Documents/List-of-RCFE-facilities.pdf.

Procedure:

05.18.05A Referring Agency

The waiver is operated by the DHCS-Long-Term Care Division, Monitoring and Oversight Section (MOS). DHCS has also contracted with Care Coordinator Agencies (CCAs) to conduct some aspects of the ALW process.

The CCAs conduct the Level of Care Assessment for customers who are approved Medi-Cal with or without a SOC, or if married or have a registered domestic partner, were denied due to excess property.

05.18.05 B Eligibility

Customers from any county may request enrollment into this waiver if they are willing to move to an ALW provider site in another county. Therefore, any county may be required to make a Medi-Cal eligibility determination using ALW eligibility rules for a waiver customer who resides in its county but who, if enrolled in the ALW, will move to another county where an ALW facility is located. Regular Medi-Cal rules for determining which county is responsible for the eligibility determination apply.

When one county's Medi-Cal resident wants to enroll in the ALW and will then move to an ALW provider site in another county, then:

- The current County of residence will determine whether an intercounty transfer is appropriate
- The current County will conduct any necessary Medi-Cal eligibility determination for that resident
- An intercounty transfer is not required when there is a married couple, both receiving Medi-Cal, and one moves into a long-term care or assisted living facility in another county, and one stays in the current county

When a customer asks the county about the ALW:

- Assist the customer with their Medi-Cal needs, be it applying for Medi-Cal or a change in circumstance
- Refer the customer to the CCA, a list of CCAs can be found at: https://www.dhcs.ca.gov/services/ltc/Documents/Care-Coordination-Agencies.pdf.

Refer to processing Guide 25 for steps when ALW is requested and no referral from the CCA has been received.

05.18.05C Institutional Deeming/Special Rules

When an ALW referral is received and it's determined that the customer will be property ineligible or has a SOC using regular Medi-Cal rules, the special rules below apply:

- The customer is treated as if they were institutionalized for purposes of the treatment of income and resources. If the customer is a child, parental income and resources are not considered even though the child lives in the home
- A second vehicle is exempt if the vehicle has been modified to accommodate the physical handicap(s) or medical needs of the customer. Verification is by the physician's written statement of necessity
- The customer is in their own Medi-Cal Family Budget Unit (MFBU). If other family members wish to be aided, the customer is treated like those on public assistance (PA). The waiver customer may be used to link other family members although the customer is not in the family's MFBU

- The ALW customer must be eligible for full benefits with or without a SOC
- Use the most beneficial full-scope Medi-Cal program to determine eligibility that is applicable to the customer, for example, Pickle, the Aged and Disabled (A&D) program, or the Medically Needy (MN) program. Eligibility is based on the customer's own income and resources, including amounts remaining after Spousal Impoverishment (SI) are applied
- Evaluate as if the customer were residing in a licensed Board and Care (B&C). Deduct the greater of the excess B&C deduction or the $315 Petit v. Bonta deduction for personal care service, see MPG 10.06.08

  The amount to be used as the paid amount to the licensed B&C facility is the AL facility rate determined as follows:
  - The difference between the Supplemental Security Income/State Supplemental Program (SSI/SSP) nonmedical B&C payment level and the minimum personal care and incidentals needs rate is defined for purposes of the AL waiver as the AL facility rate

  For example, as of December 1, 2020, the AL facility rate to be used is $1069.37 ($1206.37-$137.00), see MPG 11.1A.

- A disability determination is not required unless:
  - Eligibility is based on a Medi-Cal program requiring that the customer be disabled
  - The customer has no other basis for linkage
  - There would be an advantage if the customer were disabled, for example, income deductions available only to the disabled. If this is a child, the determination of disability may be advantageous in the future when they become an adult

Note: The Institutional Deeming/Special Rules **do not** apply to the Modified Adjusted Gross Income (MAGI) Medi-Cal program.

Refer to processing Guide 25 for steps when the customer is treated as if they were institutionalized for purposes of determining the amount of income and property the waiver customer has.

05.18.05D Aid Codes

If a customer is determined eligible for zero SOC Medi-Cal using the Institutional Deeming/Special Rules, they must be placed in one of the following aid codes:
- 14 – for aged
- 64 – for disabled

05.18.05E Notice of Action (NOA)

If a customer is to move into an ALW provider site and is then eligible using regular Medi-Cal rules, use a regular Medi-Cal NOA.

If eligibility/ineligibility is based on the use of the special ALW rules (also known as Institutional Deeming), use one of the three ALW specific notices of action below:
- MC 240 – Approval for Enrollment in Assisted Living Waiver with Medi-Cal Changes for Beneficiary
- MC 241 – Approval for Enrollment in Assisted Living Waiver and Initial Medi-Cal (only use if initial eligibility and ALW eligibility is determined simultaneously)

- MC 242 – Denial of Enrollment in Assisted Living Waiver and/or Medi-Cal Referral Form

Program Impacts:

Forms and Document Capture

The ALW NOAs are not available in CalWIN but are available in the Eligibility Forms Library (EFL) and Xerox. Follow existing procedures to Document Capture any client correspondence issued outside of CalWIN.

Automation

Refer to the Business Environment Design Strategies (BEnDS) 49130 in Eligibility Essentials for CalWIN entries when applying SI.

References:

ACWDL 90-01, 17-25, 18-19
MEPM Letter No. 307
MEPM Article 19D
MEDIL 14-38

Sunset Date:

This policy will be reviewed for continuance by 06/30/2024.

Approval for Release:

Rick Wanne, Director
Self-Sufficiency Services

Revision Date:
06/01/2021

Background:
The Department of Health Care Services (DHCS) applied for and received federal approval from the Federal Centers for Medicare and Medicaid Services (CMS) for the Acquired Immune Deficiency Syndrome (AIDS) Waiver.

Purpose:
This section will provide guidelines for the processing of the AIDS Waiver. It has been updated to reflect changes provided in All County Welfare Directors Letter (ACWDL) 18-19.

Policy:
The AIDS Waiver is limited to customers with a diagnosis of Human Immunodeficiency Virus (HIV) or AIDS with symptoms related to HIV disease who would otherwise require care in skilled nursing facilities or acute hospitals.

Services provided include:
- Case management
- Skilled nursing
- Attendant care
- Psycho-social counseling
- Non-emergency medical transportation
- Homemaker services
- Equipment and minor physical adaptations to the home
- Limited room and board supplement for infants and children in foster care
- Nutritional counseling
- Nutritional supplements/home delivered meals

Procedure:
05.18.06A Referring Agency
Medical certification for the AIDS Waiver is completed by the California Department of Public Health, Office of AIDS. The medical assessment for this waiver is completed before the customer is referred to the County.

There should be few, if any, of this type of referral to the County.

05.18.06B Eligibility
Process using regular Medi-Cal eligibility rules including the application of Spousal Impoverishment (SI) provisions if applicable; no other special Medi-Cal eligibility rules apply.

05.18.06C Notice of Action (NOA)
When a customer’s Medi-Cal eligibility is approved or denied, use a regular Medi-Cal NOA.

Program Impacts:

Automation

Refer to the Business Environment Design Strategies (BEnDS) 49130 in Eligibility Essentials for CalWIN entries when applying SI.

References:

MEM PROC 19D
ACWDL 90-01, 17-15, 17-25, 18-19
MEDIL 14-38

Sunset Date:

This policy will be reviewed for continuance by 06/30/2024.

Approval for Release:

Rick Wanne, Director
Self-Sufficiency Services