36. State Waiver Programs and Limited Services

36.1 Waivers/Programs

The Social Security Act permits states to request waivers of otherwise applicable federal law in order to provide additional services to specific groups of individuals, limit services to specific geographic areas of the state, and provide medical coverage to individuals who may not otherwise be eligible under traditional Medicaid (Medi-Cal) rules.

HCBS Waivers

Home and Community-Based Services (HCBS) Waivers (authorized under Section 1915(c) of the Social Security Act) allow the state to develop creative alternatives for individuals who would otherwise require care in a nursing facility or hospital. These waiver services can be offered in either a home or community setting and must cost no more than the alternative institutional level of care.

The Department of Health Care Services (DHCS) has several HCBS Waivers/Programs in effect. The complete list can be viewed on the DHCS Website. The following are the current waivers/programs that require a Medi-Cal (MC) eligibility determination to be completed at the county level:

- Home and Community-Based Services for the Developmentally Disabled (**HCBS-DD**) Waiver (formerly DDS-HCBS)
- Home and Community-Based Alternatives (**HCBA**) Waiver (formerly NF/AH, replaces MC IHO)
- Multipurpose Senior Service Program (**MSSP**) Waiver

Recipients of HCBS Waivers/Programs must have full-scope Medi-Cal (MC) eligibility and must also be medically certified by the designated responsible agency. The responsible agency usually completes the medical certification prior to referring the individual to the county to apply for MC. Occasionally, the medical certification is not completed until after MC eligibility is determined.

Important:

When determining MC eligibility for the waivers listed above, institutional deeming (or spousal impoverishment) applies as if the client were institutionalized. This means the income and resources that belong to the individual's parent(s) or spouse will not count toward the individual in the eligibility determination.

Personal Care Services Program

There may be HCBS waiver recipients who requested In-Home Supportive Services (IHSS) but were not eligible under the IHSS residual program because it does not allow for institutional deeming. These individuals would be eligible for the Personal Care Services Program (PCSP) administered through IHSS. Unlike the IHSS residual program, PCSP does not allow a parent of a minor child or spouse to be the care provider.

PCSP provides the following services:

- Assistance to ambulate (walk around)
- Bathing, oral hygiene, dressing, and grooming
- Care and assistance with prosthetic devices
- Bowel, bladder and menstrual care
- Repositioning, range of motion exercises and transfers
- Feeding and assurance of adequate fluid intake
- Respiration and Paramedical services
- Assistance with self-administration of medications
- Ancillary services (e.g., meal preparation, laundry, shopping and domestic services).

36.1.1 HCBS-DD Waiver

The HCBS-DD Waiver Program (formerly DDS-HCBS) was designed to serve developmentally disabled individuals who remain in their communities and homes rather than in an institutional setting.

At the program's onset, a developmentally disabled person was required to meet all the regular Medi-Cal eligibility requirements. Effective 10/1/93, eligibility requirements for the HCBS-DD program were amended to allow for institutional deeming which includes:

- The waiving of parental/spousal deeming of income and property prior to determining Medi-Cal eligibility, and

- The application of spousal impoverishment provisions as if the client were institutionalized.

San Andreas Regional Center (SARC) completes the HCBS-DD waiver medical certification and then forwards the information to the Assistance Application Center (AAC) for a Medi-Cal eligibility determination.

Benefits

The HCBS-DD Waiver Program allows for the additional medical services for certain developmentally disabled individuals who live at home or in the community instead of in an intermediate care facility.

The major differences between regular Medi-Cal and HCBS-DD Waiver Medi-Cal include the following provisions:

- Spousal impoverishment rules apply as if the applicant were institutionalized. The HCBS-DD applicant may transfer property to the spouse according to Community Spouse Resource Allowance (CSRA) rules.
    - If the client is a child, parental income and property are not considered even though the child lives in the home.
    - If the client is an adult, spousal impoverishment rules apply.
- A second vehicle is exempt if the vehicle has been modified to accommodate the physical handicap(s) or medical needs of the client. Verification must be by the physician's written statement of necessity.
- A separate MFBU is established for an individual who qualifies for Medi-Cal under the HCBS-DD Waiver Program. If other family members wish to be aided, the client may be used to link other family members although the client is not in the family's MFBU.
- Individuals certified under the HCBS-DD Waiver Program may receive additional services offered through other funding sources to enhance Medi-Cal, such as skilled nursing at home, home health services, specialized medical equipment and supplies, chore service, etc.

If the client is eligible for zero SOC MC when the income and resources of his/her parents or spouse are considered, there is no need for the special waiver program criteria. The EW must establish regular MC. Individuals eligible for MAGI MC, including the Optional Targeted Low-Income Children's Program (OTLICP) are eligible for the additional medical services without a change in aid code to 6V or 6W.

An applicant for this program must meet all of the following criteria:

- Has been certified for the HCBS-DD Waiver Program based on his/her medical, social and developmental care needs by San Andreas Regional Center (SARC).
- Is ineligible for regular MC or has a SOC when parental/spousal income and resources are considered.
- Meets all Medi-Cal requirements, however, parental/spousal income and resources are not considered and spousal impoverishment provisions may be applied.
- Is eligible for full scope MC. (i.e., A person only eligible for restricted 58 MC or a person residing in a nursing home under the State-only Aid Code of 53 is not eligible for the DDS-HCBS Waiver Program.)
- Must have MC linkage. A DDSD referral is required when no other linkage exists, the client requests it, or it is beneficial to the client.

    Note: The EW must use the most beneficial full scope MC program to determine eligibility that is applicable to the client (e.g., ABD, MN, MI, or FPL). Eligibility is based on the

DDS-HCBS Waiver client's own income and property, including amounts remaining after spousal impoverishment rules are applied.

- A DDSD referral is not required unless:
  - Eligibility is based on MC requiring that the client be disabled,
  - The client has no other basis for linkage, or
  - There would be an advantage if the client were disabled (i.e., income deductions available only to the disabled). This determination of disability may be advantageous when a child becomes an adult.

- May or may not have a SOC when the HCBS-DD Waiver rules are applied.

Application Referrals

SARC will identify potentially eligible individuals for the HCBS-DD Waiver Program. SARC will then evaluate the client for certification under the Waiver Program based on medical, social and developmental care needs. Only clients who have successfully completed the certification process are referred to the county for a Medi-Cal eligibility determination.

A "Department of Developmental Services Waiver Referral" (DHCS 7096) is mailed directly to the Assistance Application Center (AAC). The referrals are for disabled children under 18 years of age and who are living with their parents. The purpose of the referral is to give the child the advantage of being in a separate MFBU with only their own separate income and property budgeted.

- If the child is receiving MC but has a SOC, the continuing Supervisor and EW are notified to set up a SARC MFBU for the child.

- If the child is not currently receiving MC, AAC initiates an application for the child by mailing a letter and an application packet to the parent to complete.

Note:

These children are usually approved for SSI when they reach 18 years of age and parental financial responsibility ends.

Referrals may be made for:

- An application (intake) when the applicant has no current Medi-Cal record.

- A reevaluation of eligibility when the HCBS-DD applicant has an active Medi-Cal record with a SOC.

Public Agency Representative

As a public agency, SARC may apply for Medi-Cal on behalf of an incompetent person when there are no family or friends to assist them.

Written authorization is not necessary for a public agency representative to apply for Medi-Cal on behalf of incompetent individuals.

Note:

Parents must apply for Medi-Cal for their children if they are living together.

MFBU Determination

An individual who qualifies for MC under the HCBS-DD Waiver program is placed in his/her own MFBU.

Table 36-1: MFBU Determination

IF...	THEN...
There are multiple individuals in the same household applying for these waivers,	Each person is in his/her own MFBU.
Other family members are applying for or are receiving regular MC,	The HCBS-DD individual is in their own MFBU but can be used to link other family members.

HCBS-DD Aid Codes

The following Aid Codes are used for the HCBS-DD Waiver cases:

Table 36-2:

Aid Code	Description
6V	HCBS-DD Waiver aka DDS-HCBS (No SOC)
6W	HCBS-DD Waiver aka DDS-HCBS (SOC)

Reporting Responsibilities

The client/caretaker relative must report all changes within 10 days.

Budgeting Methodology

Budget methodology for a HCBS-DD case is determined by linkage.

- If the recipient is disabled (determined disabled by SP-DDSD or in receipt of disability based RSDI), then ABD income deductions are used.
- If the recipient is eligible for MC based on AFDC-MN/MI linkage, then AFDC-MN/MI budget methodology is used.

Note:

The same aid code is used whether the recipient has been determined disabled or not. The EW must enter the waiver information on the **Display Individual Attributes Summary** window on the *Health Care Information* tab to ensure that the correct budget methodology is used.

Retro Medi-Cal

HCBS-DD regulations may be applied retroactively if the HCBS-DD Waiver individual has outstanding medical bills from the 3 month period prior to application and the applicant requests it.

HCBS-DD Determination For a New Applicant

The following procedures are followed when determining Medi-Cal under the HCBS-DD waiver program:

Table 36-3: HCBS-DD Determination

STEP	WHO	ACTION	
1.	SARC	Initiates an application by mailing a "Department of Developmental Services Waiver Referral" (DHCS 7096) to the Assistance Application Center (AAC). Instructs client to apply for MC.	
2.	HCBS-DD Contact Person at AAC	Receives DHCS 7096 and/or MC Application. Ensures a SAWS 1 and SC 41 are completed. **Note:** The date AAC receives the referral form is to be used as the application date. Assigns application as follows:	
		If there is:	**Then:**
		An open case record,	Refers application to the current worker's supervisor.
		No open case record,	Refers to I.D. and assigns to AAC intake.
3.	EW	Receives application/referral and determines who is the representative for the case.	
4.	EW	Determines Medi-Cal eligibility under the HCBS-DD Waiver program.	

Table 36-3: HCBS-DD Determination

STEP	WHO	ACTION	
5.	EW	Determines linkage and submits a DDSD packet, if applicable.	
		If Applicant:	**Then a DDSD Referral is:**
		Receives Social Security due to own disability,	Not required since disability has already been established.
		Is an MI Adult and has not been determined disabled (There are no DHCS 7096 referrals on clients over age 18),	Required. Case will remain in DE-D pending status until DDSD decision is received.
		Is an otherwise eligible child (under age 21),	Recommended, but not required.* Issue MC using Aid Code 6V or 6W. • Set up a case alert for DDSD follow-up. • Use AFDC-MN/MI budgeting until DDSD decision is received. • Revise budgets as needed when DDSD decision is received.
*Note: When a HCBS-DD child enters LTC, the HCBS-DD provisions no longer apply. He/She may only remain in his/her own MFBU if he/she has been determined "disabled."			

HCBS-DD Determination for a Currently Eligible Medi-Cal Recipient

The following procedures are followed when a Department of Developmental Services Waiver Referral (DHCS 7096) is received by a continuing EW:

Table 36-4: HCBS-DD Determination

STEP	WHO	ACTION
1.	EW	Receives the DHCS 7096 and determines who is the case representative. NOTE: A new Application for MC is only needed if the annual RD is due.
		Reviews case to determine Medi-Cal eligibility under the HCBS-DD Waiver program, and submits a DDSD packet if necessary.

Notices of Action (NOAs)

Approval, denial and/or discontinuance NOA must be sent to the client and/or their AR, as applicable.

Release of Information

For HCBS-DD applicants/recipients only, a release of information is not required to share ongoing eligibility information with San Andreas Regional Center (SARC).

Redeterminations (RDs)

The EW must complete a MC redetermination annually. Income information must be requested, however, if the attested income is still over the limit for regular Medi-Cal, verification is not required for ongoing eligibility. If the attested income is within regular Medi-Cal income limits, request verification and establish ongoing MC eligibility.

SARC is also required to complete an annual medical recertification for the HCBS-DD waiver program. SARC will forward a copy of the annual medical recertification to the EW which must be sent to IDM. If the EW has not received verification of recertification from SARC by the time the annual MC redetermination is due, the EW must request the SARC liaison to contact SARC for confirmation of medical eligibility for the waiver program.

Termination of HCBS-DD Waiver

Should the individual lose his/her medical certification for the HCBS-DD Waiver, eligibility under the regular Medi-Cal program must be explored prior to discontinuance.

The HCBS-DD waiver does not apply to individuals in LTC.

36.1.2 HCBA Waiver

The HCBA Waiver allows individuals who would otherwise reside in a skilled nursing facility to remain at home and obtain MC eligibility without consideration of a parent's income or resources if the applicant were a child or used spousal institutional deeming rules if the applicant lived at home with his/her spouse.

The services under the HCBA Waiver program include case management, private duty nursing, home health aides, personal care services, respite care, family training, and minor physical adaptations to the home.

Libertana Home Health is the HCBA Waiver Agency for Santa Clara County.

The three major provisions provided under this program which are not available to other Medi-Cal clients are:

- Income and resources of the parent/spouse will not be counted if the waiver individual is otherwise ineligible for Medi-Cal.
- Eligible individuals are provided skilled nursing at home, home health aid services, therapy, etc., in lieu of inpatient services.

- A second vehicle is exempt if the vehicle has been modified to accommodate the physical handicap(s) or medical needs of the client. Verification must be by the physician's written statement of necessity.

Requirements

An applicant for the HCBA Waiver must meet all of the following requirements:

- Meets certain medical requirements which are determined by Libertana.
- Is ineligible for regular Medi-Cal or has a SOC when parental/spousal income and property are considered.
- Meets all Medi-Cal requirements, however, parental/spousal income and property are not considered and spousal impoverishment provisions may be applied.
- Has MC linkage (i.e., ABD-MN, AFDC-MN). A DDSD referral is required when no other linkage exists, the client requests it, or it is beneficial to the applicant (i.e., additional income deductions will eliminate or reduce the SOC).
- Is eligible for full scope MC.
- May or may not have a SOC when the HCBA Waiver rules are applied.

Note:

If the individual is eligible for zero SOC MC when the income and resources of his/her parents or spouse are considered, there is no need for the special waiver program criteria. The EW must establish regular MC.

HCBA Waiver Inquiries

Requests for consideration under the HCBA Waiver program can be initiated by the applicant, a physician, friends, family, LTC facility or hospital, or by a community agency. Libertana is the agency that determines if medical requirements of the HCBA Waiver are met.

When Medical Requirements are Met

If the applicant meets or is likely to meet the initial screening criteria, Libertana will refer the applicant to the County Welfare Department for a MC eligibility determination.

Institutional Deeming

The following income/property rules apply when determining MC eligibility and SOC under the HCBA Waiver program:

- Parental/Spousal income and property are not considered.
- Spousal Impoverishment rules apply as if the applicant were institutionalized.

MFBU Determination

An individual who qualifies for MC under the HCBA Waiver program is placed in his/her own MFBU. The maintenance need for one ($600) is used to determine the SOC.

The HCBA Waiver client is not included in the MFBU of other family members, but can establish linkage.

HCBA Waiver Aid Codes

The following aid codes are used for the HCBA Waiver program:

Table 36-5: HCBA Waiver Aid Codes

Aid Code	Description
6X	HCBA Waiver (No SOC) replaces IHO waiver
6Y	HCBA Waiver (SOC) replaces IHO waiver

Reporting Responsibilities

The client/caretaker relative must report all changes within 10 days.

Budget Methodology

Budget methodology for a HCBA Waiver case is determined by linkage.

- If the recipient is disabled (determined disabled by SP-DDSD or in receipt of Social Security payments based on disability), then ABD income deductions are used.
- If the recipient is eligible for MC based on AFDC-MN/MI linkage, then AFDC-MN/MI budget methodology is used.

Note:

The same aid code is used whether the recipient has been determined disabled or not. The EW must enter the waiver information on the **Display Individual Attributes Summary** window on the *Health Care Information* tab to ensure that the correct budget methodology is used.

HCBA Waiver Approval and Beginning Date of Aid

Prior to case authorization, the EW must contact the Libertana representative listed on the referral form to:

- Notify them of potential eligibility or ineligibility,
- Request a HCBA Waiver Medical Eligibility Notice confirming medical eligibility, if not already received, and
- Request the effective date of the HCBA Waiver certification. The EW must inform the Libertana representative if retroactive coverage has been requested.

The beginning date of aid can be no earlier than the effective date of the HCBA Waiver certification.

Notice of Action Requirement

The EW must issue a NOA for approval (MC 343) or denial (MC 344) of MC to all HCBA Waiver applicants (this waiver is replacing MC IHO).

Referring Agency

Libertana Home Health is the referring agency for the HCBA Waiver. Their contact information is as follows:

Libertana Home Health
5805 Sepulveda Blvd
Ste. 605
Sherman Oaks, CA 91411
Phone: 818-912-5000

36.1.3 MSSP Waiver

The Department of Aging Multipurpose Senior Services Program (MSSP) Waiver allows EWs to determine eligibility using institutional deeming rules (spousal impoverishment) for a person who:

- Moves from the institution and returns home to their spouse, or
- Is already living at home with his or her spouse.

Benefits

The MSSP provides interdisciplinary (nurse and social work) care management services including the coordination and use of existing community resources. Care managers initiate and monitor the process of assessments, case plan development, service arrangement, ongoing monitoring and reassessments of client's needs.

To arrange for services, care management staff first explore support that might be available through family, friends and community volunteers. Then they review existing publicly-funded services and make direct referrals. If needed services are not available through these resources, the care management team can authorize the purchase of some services from MSSP funds.

Eligible clients may be linked to services that include, but are not limited to:

- Care Management
- Adult social day care
- Housing assistance
- Protective services
- Meal services
- Personal care
- Respite care
- Transportation
- Special communications
- Skilled nursing health care

Eligibility Requirements

The individual must meet the following MSSP eligibility requirements:

- Age 65 or older
- Eligible for full-scope MC
- Meets all other MC requirements (e.g., residency, etc.)
- Is medically certified for the MSSP by the local MSSP site
- Currently or would be ineligible for regular MC due to excess property, has or would have a SOC when spousal income and resources are considered.

Note:

If the client is eligible for zero SOC MC even when spousal income and resources are considered, then there is no need to set up an MSSP Waiver.

Referring Agency

The California Department of Aging (CDA) is the referring agency for the MSSP. CDA contracts with either public entities or private nonprofit agencies to operate the MSSP program at the local level.

In Santa Clara County, the Council on Aging of Silicon Valley (COASV) listed below will identify potentially eligible individuals for the MSSP waiver by reviewing the applicant's health, psychosocial

needs, and functional status before making a referral to the Social Services Agency. COASV will refer and complete the “California Department of Aging (CDA) Waiver Referral” (MC 364) and mail it directly to the Assistance Application Center (AAC).

Table 36-6:

Council on Aging of Silicon Valley, Inc. 2115 The Alameda San Jose, CA. 95126 Phone: (408) 296-8290 Fax: (408) 249-8918

Release of Information

Eligibility Staff may share ongoing eligibility information with COASV. A release of information is not required.

Redeterminations (RD)

The EW must complete a MC redetermination annually. COASV is also required to complete an annual medical recertification for the MSSP waiver program.

COASV will forward a copy of the annual medical recertification to the EW which must be sent to IDM. If the EW has not received verification of recertification from COASV by the time the annual MC redetermination is due, the EW must request it from COASV for confirmation of medical eligibility for the MSSP waiver program.

Termination of MSSP Waiver

If the individual loses his/her medical certification for the MSSP Waiver, eligibility under the regular Medi-Cal program must be explored prior to discontinuance. A 10-day Notice of Action is required.

Eligibility Determination

When an MSSP referral form for a married applicant/ recipient is received and the EW determines that the individual is ineligible for MC due to excess community property or is eligible for MC but would end up with a SOC using regular MC rules, institutional deeming rules apply.

The following MC eligibility determination rules apply:

- The applicant/recipient is treated as if he or she was in LTC (institutionalized) for purposes of the treatment of income and resources.
- Spousal impoverishment rules apply

- The MSSP eligible individual is in his/her own MFBU. The MSSP individual may be used to link other family members (i.e., ABD-MN) even though the MSSP individual is not in the family's MFBU.
- The individual must be eligible for full scope MC benefits.
- The EW must use the most beneficial full-scope MC program applicable to the client (i.e., Pickle, Aged and Disabled Federal Poverty Level Program, ABD-MN program). Eligibility is based on the individual's own income and resources, including amounts remaining after spousal impoverishment rules are applied.

MFBU Determination

An individual who qualifies for MC under the MSSP Waiver program is placed in his/her own MFBU.

Table 36-7: MFBU Determination

IF...	THEN...
There are multiple individuals in the same household applying for these waivers,	Each person is in his/her own MFBU.
Other family members are applying for or are receiving regular MC,	The MSSP eligible individual is in their own MFBU but can be used to link other family members.

MSSP Determination For a New Applicant

The following procedures are followed when determining Medi-Cal under the MSSP waiver program:

Table 36-8: MSSP Process

STEP	WHO	ACTION
1	COASV	Initiates an application by mailing a "California Department of Aging Waiver Referral" (MC 364) to Assistance Application Center (AAC).
2	COASV Contact Person at AAC	Receives the MC 364 and monitors the status.
3	Clerical	Follows application processing per District Office procedures: • Completes the SAWS 1 and SCD 41 **Note:** The date the county receives the referral form is to be used as the date of application. • Performs file clearance.

Table 36-8: MSSP Process

STEP	WHO	ACTION	
4	COASV Contact Person at AAC	Assigns the application as follows:	
		If there is:	Then:
		An open case record,	Refer the application to the current worker's supervisor.
		No open case record,	Refers the application to an EW Supervisor who then assigns it to the EW.
5	EW	• Completes the regular application process. • Determines if there is a SOC under the MSSP Waiver program.	

MSSP Determination for a Currently Eligible Medi-Cal Recipient

The following procedures are to be followed when the MC 364 is received by a continuing EW:

Table 36-9: MSSP Determination for MC Recipient

STEP	WHO	ACTION
1	EW Supervisor	Receives the MC 364. Establishes a control system and assigns to current EW.
2	EW	Completes case processing as follows: • Receives the MC 364. • Reviews case to determine Medi-Cal eligibility under the MSSP Waiver program.
Note: The EW must send an MSSP approval, denial or discontinuance NOA as follows: 1) Original to the MSSP individual 2) Copy to COASV (MSSP referring site)		

MSSP Examples

Example 1

John is a 70-year-old applicant who is referred to the county by the COASV. He is living at home with his spouse. They have no minor children living in the home. The EW determines that he is property eligible but is not eligible for the Aged and Disabled (A&D) Federal Poverty Level Program and would have a SOC as an ABD-MN person. The EW then applies spousal impoverishment rules. John may allocate the lesser of his maximum income available for allocation or the community spouse income allocation (CSIA) to his spouse. His monthly SOC is based on the remaining amount of his income.The EW approves and sets up the individual in the appropriate MSSP aid code. If his spouse has income and is receiving MC, his spouse may have an increased SOC due to the new CSIA and a 10-day NOA is required.

Example 2

Tom is 65 years old and currently eligible in the ABD-MN program with a monthly SOC of $1,000. The EW receives the MSSP referral. He is living at home with his spouse and there are no minor children in the home. After the EW applied the spousal impoverishment rules, he is determined eligible for no SOC MSSP.

Example 3

Paul is 80 years old and referred to the county for an MSSP evaluation. He is living at home with his spouse and there are no minor children in the home. The EW determines that he is property ineligible for any MC program and his own income is below the ABD-MN limit. The EW then applies the spousal impoverishment rules and finds him to be property eligible. Since his income is already below the ABD-MN limit, there is no need to allocate any of his income to his spouse.

36.2 Severely Impaired Working Individuals Program

The SSI program encourages severely disabled individuals to seek and maintain employment through a work incentive program known as the Continued Medicaid Eligibility program. This program provides zero MC to working SSI beneficiaries even if their earnings are too high to allow an SSI cash payment. These individuals appear on MEDS as SSI/SSP recipients (i.e. Aid Code 60), but do not receive a cash grant.

An individual terminated from Continued Medicaid Eligibility for reasons other than his/her earnings and who continues to be blind/disabled is potentially eligible for the Severely Impaired Working Individual program (Aid Code 8G).

36.2.1 Eligibility Requirements

Individuals terminated from Continued Medicaid Eligibility may be eligible for zero SOC MC under the Severely Impaired Working Individual program. The individual must meet all of the following four basic requirements:

- Depends on MC to continue working,
- Meets all SSI/SSP requirements, except for earnings,
- Does not have sufficient earnings to replace SSI cash benefits, Medicaid and the cost of publicly funded personal and attendant care, and

- Received SSI or Continued Medicaid Eligibility in the month immediately preceding the first month eligibility for the Severely Impaired Working Individual program.

Spousal/parental income and property are considered when determining if the applicant meets the requirements listed above.

HCBA Waiver Referral

A Severely Impaired Working Individual frequently meets the criteria for medical certification under the HCBA Waiver program. If the above criteria is not met when spousal/parental income and property is considered, the EW will refer to Libertana for potential HCBA Waiver eligibility.

Procedure

MC applicants applying for the Severely Impaired Working Individual program will identify themselves to the EW. It is anticipated that very few individuals will fall into this category. Should one be encountered, ask the MC Liaison contact the MC Program Coordinator for complete procedures.

36.3 Spousal Impoverishment Provisions at Initial Request for Services

Spousal impoverishment provisions must be applied immediately in the following circumstances:

- The client requests in-home support or otherwise indicates a need for IHSS and provides verification that he/she would required nursing facility level of care for 30 consecutive days in the absence of IHSS. This can be verified by:
    - A completed MC 604 MDV
    - A completed needs assessment by IHSS
- The EW is made aware of the client's request for any of the waivers listed below and provides verification that he/she would require nursing facility level of care for 30 consecutive days in the absence of the waiver. This can be verified by:
    - A completed MC 604 MDV
    - A completed needs assessment by IHSS

Note:

Spousal impoverishment provisions also apply when an individual is already eligible for a waiver. This section only refers to those individuals who have requested a waiver or IHSS but have not yet been approved.

36.3.1 Impacted Waivers and Programs

The impacted waivers and programs are as follows:

- Developmental Disabilities State Plan Services
- Assisted Living Waiver
- Cal Medi-Connect Duals Demonstration Project for members eligible to receive Home and Community-Based Services and who would require institutionalization in the absence of HCBS instead of institutional services provided under Care Plan Options
- California Community Transitions Home and Community-Bases Services Money Follows the Person Grant
- CBAS Medi-Cal 2020 Demonstration Waiver Benefit
- Home and Community-Based Services for Persons with Developmental Disabilities (HCBS-DD) Waiver
- Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) Waiver
- Multi-purpose Senior Services Program (MSSP) Waiver
- Home and Community-Based Alternatives (HCBA) Waiver (formerly NF/AH)
- Pediatric Palliative Care Waiver
- Program of All-Inclusive Care for the Elderly
- Self-Directed Program for Persons with DD Waiver (program in the approval process)
- Senior Care Action Network Fully Integrated Dual Eligible Special Needs Plan
- IHSS Community First Choice Option (CFCO)

Important:

If the Community Spouse becomes institutionalized or requests one of the Impacted Waivers or Programs, he or she no longer meets the definition of Community Spouse and the spousal impoverishment provisions no longer apply.

36.3.2 Doctor's Verification Form (MC 604 MDV)

The MC 604 MDV can be used to verify that the client would likely require nursing facility level of care for 30 consecutive days in the absence of HCBS. This form must be used when there is no other verification from the Waiver administrator. The EW should complete the **Patient's Information** section on the first page and the client must complete the **Patient Authorization** section on the second page.

Note:

The *Witness* section is only required when the client signs their name with an X or illegible/foreign characters.

If the doctor does not return the form within 10 business days, contact the doctor's office to confirm they received the form and send another copy if they did not. The client can bring the form to the doctor if they choose to, however, the doctor must return the form to the county. If the client returns the form to the county, the Eligibility Worker (EW) must call the doctor's office to confirm the validity of the form. If the EW still does not receive the form after an additional 10 days, advise the client that they will be evaluated for Medi-Cal without the application of spousal impoverishment rules until a needs assessment is provided by the Waiver administrator or the MC 604 MDV is provided by a doctor.

If the needs assessment or MC 604 MDV is later provided, reevaluate MC using spousal impoverishment rules as of the date of application or date of initial request (whichever was more recent).

36.3.3 Continuous Period

Once it is determined that the client meets all of the above requirements, a Continuous Period period begins. The EW must instruct the client to report when they are approved or denied for the requested waiver/program. The EW must follow up at the next Redetermination if the client has not reported the status by then.

Continue to apply spousal impoverishment rules until:

- Verification is received stating the client did not meet the requirements for the requested waiver,
- The Community Spouse (non-Waiver spouse) becomes institutionalized or requests a waiver/program, OR

- One of the following changes in circumstances occurs:
  - Death,
  - Moves out of state,
  - Marriage ends, OR
  - No longer in need of services

Important:

A Continuous Period does not end when an individual on one of the Impacted Waivers/Programs is institutionalized.

36.3.4 Waiver-Specific Exemptions

Special exemptions allowed by waivers (e.g., the board and care income deduction for the Assisted Living Waiver) must not be applied prior to approval for the waiver. After the deduction of the CSRA from the spouses' combined community and separate property, any special waiver exemptions apply. After the deduction of the spousal income allocation, any special waiver deductions apply to the Waiver Spouse's net nonexempt income remaining before the SOC result is determined.

If the waiver the individual becomes eligible for allows an income allocation to the Community Spouse, then institutional deeming no longer applies.

36.3.5 CalWIN Functionality

Due to system limitations, a workaround is required for these cases. Refer to Systems Announcement 338 for more information.

36.3.6 Spousal Impoverishment Process

Follow the steps below when an individual requests a Waiver/IHSS.

Table 96: Spousal Impoverishment Process

<table>
<tr><th>Step</th><th>Action</th><th colspan="4"></th></tr>
<tr><td rowspan="8">1.</td><td colspan="5">Refer the client to IHSS or a Waiver administrator as appropriate (refer to chart below).
Note:
If the client has already applied for a Waiver or IHSS CFCO, a referral is not necessary.</td></tr>
<tr><td>If the client...</td><td colspan="4">Then...</td></tr>
<tr><td>Is eligible for zero-SOC MC or unmarried,</td><td colspan="4">Evaluate eligibility per normal business process.</td></tr>
<tr><td rowspan="4">Is married and ineligible due to property or is only eligible for MC with a SOC,</td><td colspan="4">Complete the Patient's Information section of the MC 604 MDV and mail to the client's doctor.
Note:
If the client has a Needs Assessment from the waiver administrator or IHSS, the MC 604 MDV is not required.</td></tr>
<tr><td>If the form is...</td><td colspan="3">Then...</td></tr>
<tr><td>Not returned, or indicates the client would <u>not</u> require 30 or more consecutive days of Skilled Nursing Facility level of care in the absence of the waiver/IHSS,</td><td colspan="3">Evaluate eligibility per normal business process. Do not transfer the case.</td></tr>
<tr><td>Returned indicating the client would require 30 or more consecutive days of Skilled Nursing Facility level of care in the absence of the waiver/IHSS,</td><td colspan="3">Transfer the case to Intake at the Medi-Cal Benefit Assistance (MBA) office or to the Continuing Benefits Service Center (BSC) LTC unit (as applicable). These specialized units will proceed to the next step for processing.</td></tr>
</table>

Table 96: Spousal Impoverishment Process

Step	Action					
2.	Determine if the client is property eligible. The Waiver/IHSS spouse's property must be under the Community Spouse Resource Allowance plus $2,000 (the property limit for one) in order to be property eligible in the initial determination. Once eligibility is approved, the client would then have 90 days to transfer all but $2,000 of the property out of their name. **Note:** Periods of Ineligibility do not apply to this population as they are not in a Skilled Nursing Facility. If the client is not property eligible, deny/discontinue the case.					
3.	Complete the "Budgets for HCBS Spousal Impoverishment" (SCD 2511) for evaluations on or prior to November 30, 2020. Complete the "Budget Steps for HCBS SI_12/2020" (SCD 2589) for evaluations on or after December 1, 2020. Complete the Potential Spousal Income Allocation section on page 1. Complete Budget A which evaluates for A&D FPL. If the client is determined eligible at the end of Budget A, proceed to the next Step in this workflow. If the client is ineligible at the end of Budget A, continue completing Budget B for 250% WDP eligibility. If the client is ineligible at the end of Budget B, complete Budget C to determine if the client is eligible for MN/MI. Refer to Systems Announcement 338 for an example.					
4.	Follow the steps in Systems Announcement 338 for required CalWIN entries.					
5.	If the client is determined eligible under HCBS Spousal Impoverishment provisions while they are applying or on a waitlist for one of the specified waivers/programs, instruct the client to notify the county when they are approved/denied.					
	If the client...	Then...				
	Reports they have been approved for the waiver/program,	Document in Case Comments that the individual has been approved for the waiver/program.				
	Reports they have been denied for the waiver/program,	• Reevaluate Medi-Cal without applying Spousal Impoverishment provisions. If the individual was removed from a combo CF/MC case and put on an MC-only case, discontinue the MC-only case and reevaluate the individual for MC on the original case with the rest of their household. • Remove the Spousal Impoverishment Special Indicator. • Case Comment				
6.	Does not report anything before the next RD,	The EW must follow up with the waiver/program administrator, or request verification from the client regarding whether or not the waiver has been approved/denied or if the client is still on the waitlist.				

36.3.7 Community Spouse Applies for MC, Becomes Institutionalized, or Requests Waiver/Program

if the Community Spouse requests MC then he/she will need to spend down his/her property to the property limit for one. A spousal income allocation would still be allowed and the spouses can adjust the amount however they determine will best preserve their eligibility.

If the Community Spouse becomes institutionalized or requests a waiver/IHSS, spousal impoverishment provisions no longer apply.

Example 1

Israel, a Community Spouse, decides to apply for Medi-Cal and has net nonexempt income that is $200.00 under the A&D FPL limit and had previously been receiving a higher spousal income allocation from Judy, the Waiver Spouse. If the couple decides it is more beneficial to ensure zero SOC eligibility for Israel, they may decide to reduce or stop the spousal income allocation, even though this would increase the net nonexempt income of Judy and potentially increase her SOC.

Judy's Income	Israel's Income
$2,000.00 (Social Security)	$900.00 (Social Security)
-$20.00 (Income Deduction)	-$120.90 (Medicare Premium)
-$120.90 (Medicare Premium)	=$779.10 (Gross income minus Other Health Insurance)
-$230.00 (Standard Deduction)	$3,023.00 (MMMNA for 2017)
-201.90 (Spousal Income Allocation)	+201.90 (Israel wants MC under the A&D FPL program, therefore only $201.90 may be allocated)
=$1,427.00 (Net nonexempt income)	=$981.00
-$600.00 Maintenance Need for 1	-$981.00 (A&D FPL Income Limit for 2017)
=$827.00 (SOC)	$0 (Excess Income)

36.3.8 Waiver and Programs Eligibility Chart

Program	Description	Target Criteria	Waiver Administrator	Referral Contact
Assisted Living Waiver	Offers Medi-Cal members the choice of residing in an assisted living setting as an alternative to long term care placement in a nursing facility.	• Ages 21 and older • Must be eligible for zero-SOC Full Scope Medi-Cal • Must otherwise require Skilled Nursing Facility level of care • Available in facilities located in the following counties: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, **Santa Clara**, San Diego, San Joaquin, San Mateo, and Sonoma.	Department of Health Care Services (DHCS)	Institute on Aging-Complete the online intake form.
Cal Medi-Connect Duals Demonstration Project	Fully integrated health plan model that provides coordinated health care and LTSS delivery to seniors and people with disabilities who are dually eligible for both Medicare and Medi-Cal.	• Ages 21 and older • Resides in Los Angeles, Orange, Riverside, San Bernardino, **Santa Clara**, San Diego, or San Mateo counties.	DHCS	Health Care Options: (844) 580-7272
California Community Transitions (CCT)-Money Follows the Person Grant	Funds the identification and transition of people with chronic conditions and disabilities from institutional settings back into a community home or homelike setting.	• Reside in a state-licensed health care facility for a period of 90 consecutive days.	DHCS	Institute on Aging-Complete the online intake form.
Community-Based Adult Services (CBAS)-Medi-cal 2020 Waiver Benefit	CBAS is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to Medi-Cal beneficiaries that meet CBAS eligibility criteria. CBAS is a Medi-Cal Managed Care benefit available to eligible Medi-Cal recipients enrolled in Medi-Cal Managed Care. Eligibility to participate in CBAS is determined by the recipient's Medi-Cal Managed Care Plan.	• Aged or disabled adults	California Department of Aging	(916) 419-7500

Program	Description	Target Criteria	Waiver Administrator	Referral Contact
Home and Community-Based Services for Persons with Developmental Disabilities (HCBS-DD) Waiver	Serves people with developmental disabilities in their own homes and communities as an alternative to placing Medi-Cal eligible individual in hospitals, nursing facilities, or intermediate care facilities, while preserving their independence and ties to family and friends.	• Developmental disabilities, • Intellectual disabilities, • No age limit • Condition must be developed/diagnosed before 18th birthday	DDS	SARC
HIV/AIDS Waiver	Provides services to allow people with AIDS to remain in their homes, stabilize their health, improve their quality of life, and avoid costly institutionalization.	• Diagnosed with HIV/AIDS • No age limit	CA Department of Public Health	(916) 449-5900
IHSS Community First Choice Option (CFCO)	Help pay for services provided to a Medi-Cal member so that they are able to safely remain in their own home. Types of services authorized through IHSS: • Housecleaning, meal preparation, laundry, grocery shopping, personal care services, accompaniment to medical appointments, and protective supervision for the mentally impaired.	• No age limit, • Aged, blind, or disabled, • California resident, • Medi-Cal approval • Live at home • Complete Health Care Certification form	IHSS, Santa Clara County	
Multipurpose Senior Services Program (MSSP) Waiver	Arranges for and monitors the use of community services to prevent or delay premature institutional placement. MSSP provides comprehensive care management to assist frail elderly individuals to remain at home. Services provided through MSSP funds include: Adult day care, housing assistance, chore and personal care assistance, protective supervision, respite, transportation, meal services, etc.	• Age 65 or older, • Live within the Site's service area	CA Department of Aging	(916) 419-7500
Home and Community-Based Alternatives Waiver	Provides Medi-Cal members with long-term medical conditions who meet one of the designated levels of care, the option of returning to and/or remaining in their home or home-like community setting in lieu of institutionalization.	• No age limit	DHCS	Libertana

Program	Description	Target Criteria	Waiver Administrator	Referral Contact
Pediatric Palliative Care (PPC) Waiver	Allows children who have a California Children's Services eligible medical condition with a complex set of needs, and their families, the benefits of hospice-like services.	• Ages 20 and younger	DHCS	(916) 552-9322
Program of All-inclusive for the Elderly (PACE)- Managed Care Product	Fully integrated health plan model that provides coordinated health care and LTSS delivery to seniors requiring nursing facility level of care with the goal of maintaining them in their homes and communities.	• Ages 55 and older • Resides in plan zip code service area in Alameda, Contra Costa, Fresno, Humboldt, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, **Santa Clara,** San Diego, or San Francisco counties.	DHCS	(916) 440-7538
Section 1915(i)- State Plan Option	Serves people with developmental disabilities in their own homes and communities while preserving their independence and ties to family and friends.	• Developmental Disabilities • Intellectual Developmental Disabilities • No Age Limit • Condition must be developed/diagnosed by 18th birthday	Department of Developmental Services (DDS)	(916) 654-1972
Self-Directed Program for Persons with DD (SDP) Waiver	Serves people with developmental disabilities and allows the participants the opportunity to accept greater control and responsibility regarding their delivery of needed services.	• Developmental disabilities, • Intellectual developmental disabilities, • No age limit	DHCS	(916) 654-1972
Senior Care Action Network (SCAN)- Fully Integrated Dual Eligible Special Needs Plan	Fully integrated health plan model that provides coordinated health care and LTSS delivery to seniors who are dually eligible for both Medicare and Medi-Cal	• Ages 65 and older • Medicare A/B • Full Scope MC without SOC • Resides in Los Angeles, Riverside, or San Bernardino counties. **NOTE:** NOT Santa Clara County	DHCS	(800) 559-3500 (SCAN) (844) 580-7272 (Health Care Options)

36.4 Limited Services Due to Program Abuse

Recipients who seek out and repeatedly obtain unnecessary services are placed on Limited/Restricted Service Status. Providers are alerted through the MC verification system that for these recipients, prior authorization is required for certain services. Any MC recipient can be placed on Limited/Restricted Service Status.

36.4.1 DHCS Responsibility

DHCS prepares and sends a “Notice of Action, MC Coverage Restricted” (MC 1705) to the client at least 10 days before restricted service status becomes effective. A copy of the MC 1705 is sent to the County and forwarded to the EW. The NOA must be scanned into IDM.

Limited/Restricted Service is in effect for a minimum of one year, unless altered by DHCS or a state hearing decision.

Note:

Limited/Restricted service status must not be lifted because of the hearing request.

The restricted service messages are:

- Restricted Drugs, coded “R1”
- Restricted Scheduled Drugs, coded “R5”
- Restricted M.D. Visits, coded “R11”
- Restricted Drugs/M.D., coded “R12”
- Restricted to Primary M.D., coded “R14”
- Restricted to Primary M.D./Drugs, coded “R15”

DHCS reviews and, if appropriate, authorizes all MC drug and/or M.D. visit requests for the customer. (Providers have been informed by provider bulletin that prior departmental approval is required by the special coding indicated.)

36.4.2 County Responsibility

EWs are responsible for accepting and forwarding requests for state hearing from individuals who want to appeal their restricted service status. Send the requests to the Appeals Unit.

- Restricted service beneficiaries may request a state hearing within 90 days of the initial action by DHCS.
- Restricted service status must not be lifted because of the hearing request.

There is no effect on the other MFBU members when a person in the MFBU is placed on limited/restricted status.

36.4.3 MC Benefits Issuances

There are NO special indicators which the EW must enter into CalWIN for those individuals who have been placed on limited/restricted status.

- DHCS will automatically input information into MEDS indicating the person has been placed on limited service status.
- DHCS will also automatically input restricted service status information into MEDS for individuals with a SOC and who are placed on limited services.

36.5 Limited Services for MIAs in SNF/ICF

The State discontinued the Medically Indigent Adult (MIA) category from the Medi-Cal program, with a few exceptions. One of the exceptions is the category of MIAs residing in a skilled nursing facility (SNF) or intermediate care facility (ICF) who are identified by Aid Code 53. While a MIA is residing in an SNF/ICF, they are entitled to all benefits normally covered by Medi-Cal. However, should that MIA person become an inpatient at an acute care hospital, any services provided during that hospital stay will not be covered by the Medi-Cal program.

36.5.1 County Responsibility

If acute care is needed, it may be provided through the Health Care Access Program within Santa Clara County's health system. The EW must refer any aid code 53 MIA person to the Health Care Access Program when that person becomes an inpatient at an acute care facility [Refer to MC HB ch. 4.1.1]. Do not refer the customer to Medi-Cal Benefits Assistance (MBA).

The MIA individual who goes to an acute care hospital outside of the county's health system will usually be referred by the hospital to VMC/O'Connor/St. Louise Regional if he/she has no other health coverage.

If a disability evaluation is subsequently approved, Aid Code 53 must be changed to a disabled aid code category effective with or retroactive to the disability onset date.

36.5.2 Medi-Cal Benefits

Aid Code 53 identifies a recipient as eligible for Medi-Cal benefits limited to services received while residing in an SNF/ICF. The Medi-Cal record for individuals who are eligible for Aid Code 53 contains the following restriction message:

"Services to acute hospital inpatients are not covered."

36.5.3 Retroactive Medi-Cal

MIAs may be eligible for retroactive Medi-Cal if both of the following conditions are met:

- The MIA resided in an SNF/ICF for one day or more during the month of application, and
- The MIA resided in an SNF/ICF for one day or more during the retroactive month(s) for which Medi-Cal coverage is requested.

The retroactive month(s) are also coded with Aid Code 53, and the same services are covered in the retroactive month as in the current month of eligibility.

36.5.4 Reimbursements of IHSS CFCO Provider Payments Due to a Retroactive Spousal Impoverishment Evaluation

Retroactive Spousal Impoverishment evaluations for the IHSS CFCO waiver population can be evaluated back to the HCBS Spousal Impoverishment program implementation date of January 1, 2014. If an individual is found retroactively Medi-Cal eligible or is currently Medi-Cal eligible and their benefit is positively impacted by a retroactive Spousal Impoverishment evaluation (lower SOC) they may seek reimbursement for IHSS provider payments through the Conlan II reimbursement process.

Individuals seeking reimbursement for IHSS CFCO provider payments must have their retroactive IHSS eligibility established, retroactive Medi-Cal eligibility established and have a completed "Doctors Verification Form" (MC 604_MDV completed for the retroactive time period. Once the criteria are met, the recipient must contact the Beneficiary Service Center at (916) 403-2007 to request a Conlan II claim packet for IHSS. The Beneficiary Service Center will determine whether the claim is valid and the reimbursement amount. Individuals must contact the Beneficiary Service Center directly for any reimbursement related questions.

36.5.5 Undocumented Immigrants in LTC

There are special procedures for non-linked undocumented immigrants who are in LTC. Do not use Aid Code 53 for an undocumented individual unless he/she is seeking PRUCOL status from INS.