State of California—Health and Human Services Agency
Department of Health Care Services

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TO: ALL COUNTY WELFARE DIRECTORS Letter No: 18-19
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS
CALIFORNIA DEPARTMENT OF AGING
CALIFORNIA DEPARTMENT OF DEVELOPMENTAL SERVICES
CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
ALL HCBS WAIVER ADMINISTRATORS/COORDINATORS

SUBJECT: Supplement to Home and Community-Based Services and Spousal Impoverishment
(References: All County Welfare Directors Letters, Numbers 87-77, 90-01, 90-03, 91-84, 12-36, 17-03,17-25; Medi-Cal Eligibility Procedures Manual, Article 19)

Purpose

The purpose of this All County Welfare Directors Letter (ACWDL) is to build on, and not supersede ACWDL 17-25 by expanding on existing policy guidance.

This letter will provide guidance on:

- How the Spousal Impoverishment (SI) provisions apply to registered domestic partnerships;
- The hierarchy for determining eligibility when applying the SI provisions;
- Determining when the SI provisions apply;
- The process for applying the SI provisions to cases with a Home and Community-Based Services (HCBS) spouse and a community spouse;
- The ongoing eligibility of the HCBS spouse once eligibility is determined;
- Determining eligibility for the community spouse who applies for Medi-Cal subsequent to the HCBS spouse's eligibility determination;

- Retroactive eligibility under SI for HCBS;
- Retroactive reimbursement under the Beneficiary Reimbursement Process (aka Conlan Process); and
- An overview of the annual renewal process for this population.

This letter provides the counties with the following enclosures:

Enclosure 1: Budget Steps Worksheet for HCBS Spousal Impoverishment

Enclosure 2: List of HCBS Waivers by County

Enclosure 3: HCBS Waiver Wait List Flyer for Distribution

Enclosure 4: County Resources for Beneficiary Reimbursement Process (aka Conlan Process)

Enclosure 5: Provider NewsFlash Asking Providers to Promptly Complete MC 604 MDV Doctor's Verification Forms

Enclosure 6: Example 3: Spousal Impoverishment Provisions Applied Retroactively

Enclosure 7: Diagram 1: Community Spouse Resource Allowance (CSRA) Transfer Period

Enclosure 8: Diagram 2: Completion of Request for HCBS

Enclosure 9: Diagram 3: Continuous Period of Institutionalization (HCBS).

Background

ACWDL 17-25, released on July 19, 2017, broadened the application of SI provisions when determining Medi-Cal eligibility for those who have requested, or are receiving, HCBS. As stated in ACWDL 17-25, the Affordable Care Act (ACA) broadened the definition of an "institutionalized spouse"[1] to include HCBS recipients and persons who have requested HCBS, who (generally) reside at home or in the community.
The Department of Health Care Services (DHCS) convened a workgroup to provide technical assistance to the counties in implementing ACWDL 17-25. While providing

[1] Section 1924(h) of the Social Security Act and by reference, therein, Section 1902(a)(10)(A)(ii)(VI).

technical assistance and in partnership with workgroup participants, DHCS identified several areas where existing policy guidance could be strengthened.

The SI provisions are financial methodologies that allow the community spouse to retain more income and property upon submission of a Medi-Cal application for the institutionalized spouse.

The SI provisions for institutionalized individuals were enacted initially through the Medicare Catastrophic Coverage Act, a federal law that changed the treatment of property owned and income received by institutionalized spouses and their community spouses for Medicaid eligibility purposes. DHCS implemented the SI provisions through the release of ACWDLs 90-01 and 90-03, which relate to property and income, respectively. In California, the SI provisions permit a community spouse to retain the CSRA and the institutionalized spouse may provide a spousal income allocation for the maintenance of the spouse as well as dependent family member allocations.

More recently, federal law, through the ACA, broadened the application of those SI protections to HCBS spouses with community spouses who may be residing in their own homes (not institutionalized). ACWDL 17-25 outlined the process for applying the SI provisions to individuals added under the expanded definition of "institutionalized spouse" in the ACA.

ACWDL 17-25 added the SI provisions as an eligibility step for HCBS applicants and recipients. As stated in ACWDL 17-25, the expanded definition permits the use of SI for the following HCBS programs and waivers:

- Section 1915(i) Developmental Disabilities State Plan Services
- Assisted Living Waiver (ALW)
- Cal Medi Connect Program Duals Demonstration Project for members eligible to receive HCBS, and who would require institutionalization in the absence of HCBS (Community-Based Adult Services [CBAS], Multi-purpose Senior Services Program), in lieu of institutional services provided under Care Plan Options
- Money Follows the Person Grant – California Community Transitions (through December 31, 2018)[2]
- CBAS Waiver – California Medi-Cal 2020 Demonstration
- HCBS Waiver for the Developmentally Disabled (HCBS-DD)
- Section 1915(c) HCBS AIDS Medi-Cal Waiver Program
- In-Home Operations Waiver

[2] Individuals will not be able to access the California Community Transitions program after December 31, 2018, as funding will cease.

- Community First Choice Option (CFCO)
- MSSP Waiver
- Home and Community-Based Alternatives Waiver (formerly Nursing Facility/Acute Hospital – Transition and Diversion Waiver)
- Pediatric Palliative Care Waiver (through December 31, 2018)[3]
- Program of All-inclusive Care for the Elderly (PACE)
- Self-Directed Program for Persons with DD Waiver
- Senior Care Action Network – Fully Integrated Dual Eligible Special Needs Plan.

A list of California's 1915(c) HCBS Waiver programs by county is attached to this letter as a resource (see Enclosure 2).[4] Individuals can request and participate in some HCBS waivers and programs, such as ALW or PACE, that are in a different county than where the community spouse resides.

1. Spousal Impoverishment Provisions Apply to Registered Domestic Partnerships

The SI provisions apply to registered domestic partners (RDPs). ACWDL 12-36 establishes that the full array of spousal protections that are/were available to married, opposite-sex couples extend to same-sex spouses and RDPs.[5] Specifically, the rules regarding the amount of income and property a community spouse may retain when his/her spouse is an institutionalized spouse (i.e., the SI provisions) apply also to same-sex spouses and RDPs.

2. Hierarchy for Determining Eligibility When Applying Spousal Impoverishment Provisions

Federal law specifies that certain programs be considered before others when Medi-Cal eligibility is determined or redetermined. At application, annual renewal, or when a change of circumstances is reported, the applicant or beneficiary's Medi-Cal eligibility must be determined by progressing through the Medi-Cal hierarchy outlined in ACWDL 17-03. The applicant/beneficiary may not be eligible for some programs after the screening. Eligibility must be determined for each program where the applicant/beneficiary has potential Medi-Cal eligibility. When an applicant/beneficiary is eligible for more than one Medi-Cal program, and one is more beneficial than others,

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[3] Individuals will not be able to access the Pediatric Palliative Care Waiver after December 31, 2018.
[4] This list is subject to change.
[5] Pursuant to Assembly Bill (AB) 641 (Feuer-Chapter 729, Statutes of 2011), as implemented in ACWDL 12-36.

the individual must be placed in the Medi-Cal program that is most beneficial for him/her, unless the individual requests otherwise.
As a reminder, the order or hierarchy in which Medi-Cal eligibility must be determined is:

Mega Mandatory and Mandatory Categorical Groups
Modified Adjusted Gross Income (MAGI)[6]
Non-MAGI Optional Categorical
Non-MAGI Medically Needy (MN)/Medically Indigent
Non-MAGI (State Only)

Pickle is a Mega Mandatory program. Mega Mandatory programs are those that are categorical/mandatory programs required by federal law or where eligibility is determined by another program that automatically includes Medi-Cal eligibility as part of the determination. When evaluating eligibility under Pickle, apply the SI provisions at the same time, not "first" or separately, in the determination process.

As stated in ACWDL 17-25, when applying the SI provisions the Non-MAGI hierarchy is:

Aged, Blind and Disabled Federal Poverty Level group
250 Percent Working Disabled program
MN with or without a share-of-cost (SOC)

3. Determining When to Apply the Spousal Impoverishment Provisions

ACWDL 17-25 requires the county eligibility worker (CEW) to apply the SI provisions in the first month when both of the following exist:

- The request[7] for either HCBS or In Home Supportive Services (IHSS) has been made, **and**
- The individual meets a nursing facility level of care as determined by a doctor[8] or through an assessment by the HCBS waiver or program.

The date that both these criteria are met is known as the **applicable application date** for SI provisions.

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[6] Check for eligibility using MAGI, but remember that the SI provisions do not apply until Non-MAGI is being evaluated.
[7] The request for HCBS or IHSS can be made verbally, or in writing, or by answering "yes" to the question on the Medi-Cal application.
[8] The level of care needed by the individual is documented through the DHCS MC 604 MDV Doctor's Verification form.

If the applicant/beneficiary has not yet received a needs assessment by the waiver program or IHSS, the CEW must obtain documentation that the applicant meets the nursing facility level of care requirement through the DHCS MC 604 MDV Doctor's Verification (Doctor's Verification) form in order to apply the SI provisions.[9] If a Doctor's Verification is necessary, counties must provide the form to the applicant/beneficiary as soon as the request for IHSS or HCBS is made. The Doctor's Verification process provides a bridge for services while the individual is waiting for a needs assessment, whether they are on a waiver wait list or not.

The Doctor's Verification form must be signed by the person requesting HCBS waiver or program services to authorize release of the HCBS spouse's information to the county. The county then must send the form to the doctor identified by the HCBS or community spouse with the county's postage-paid, return envelope and must provide at least 10 business days to submit the form to the county.[10]

Reminder: Counties also must accept completed forms from the beneficiary or authorized representative following the process outlined in ACWDL 17-25.

The SI provisions must be applied to HCBS spouses who request IHSS and provide a completed Doctor's Verification form indicating a need for nursing facility level of care for at least 30 consecutive days (with a beginning date that is on or after January 1, 2014). If individuals request IHSS, they do not need to say they are requesting IHSS-CFCO. Any IHSS request is adequate. Similarly, any request for HCBS must trigger the Doctor's Verification process.

Before applying the SI provisions, the CEW does not need to check that the HCBS requester actually has applied for a waiver or program. The CEW must:

1) Apply the SI provisions to a HCBS spouse
2) Complete authorizations to release information to and from IHSS and to and from the HCBS waivers and programs
3) Establish contact with the IHSS eligibility worker or HCBS waiver administrator/ care coordinator and provide authorizations to release information

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[9] Counties must provide translation service in accordance with state and federal law. See ACWDL 18-17 for the translated MC 604 MDV forms.

[10] A June 2018 Provider Bulletin/NewsFlash (NewsFlash) was issued by DHCS to remind providers that these forms should be completed promptly. The NewsFlash is attached to this letter as Enclosure 5. Counties may print the NewsFlash and forward it with the Doctor's Verification form as an informal cover letter to the doctor explaining the essential role of the form in screening for Medi-Cal eligibility.

4) Make a referral if the individual has not yet applied
5) Document in the case record the contact information and relevant dates
6) Request that the contact provide follow-up information on dates and participation approvals/determinations.
7) In sufficient time to issue a 10-day Notice of Action (NOA) before the end of the continuous period of institutionalization, check with the contact to ensure the HCBS request has been completed by an actual application or placement on a wait list.

The Doctor's Verification form and the needs assessment serve different functions and are not interchangeable. Both may be required for an individual requesting in-home care depending on the timing of the request for services and their individual circumstances. The purpose of the Doctor's Verification form is to verify that the individual requires a nursing facility level of care for at least 30 consecutive days in the absence of in-home care and support services, and typically will be used in cases where there has not yet been a needs assessment. The Doctor's Verification form is completed by a medical doctor using his/her medical judgment as to whether nursing facility level of care is needed and the date when it was first needed by the individual. It is one of the two criteria to trigger the application of SI provisions.

In contrast, the needs assessment is completed at the individual's home, hospital, skilled nursing facility or rehabilitation center, and is conducted by a social worker or eligibility screener, who makes a clinical determination based on a functional index scale. A needs assessment is a requirement for IHSS-CFCO and other HCBS waivers and programs. CFCO is the only IHSS program that provides the appropriate level of care to trigger application of the SI provisions.

Instead of waiting for those individuals to specifically ask for information about SI, counties must screen individuals who potentially may benefit from the application of the SI provisions at application, renewal and when reporting a change.

Counties must apply SI provisions to married individuals and RDPs who, on or after January 1, 2014, are/were:

- New Medi-Cal applicants who request HCBS waiver services
- New Medi-Cal applicants who request in-home assistance on their application
- New Medi-Cal applicants who request IHSS
- On a HCBS waiver wait list and are not presently receiving Medi-Cal
- On a HCBS waiver wait list and are receiving Medi-Cal
- In a HCBS waiver (in institutional deeming aid codes 1X, 1Y, 6V, 6W, 6X or 6Y)
- CFCO recipients any time after January 1, 2014 (aid code 2K)

- Received HCBS waivers or program services and have Medi-Cal with a SOC any time after January 1, 2014 and prior to the pending month
- Received IHSS and have a SOC any time after January 1, 2014, and prior to the pending month
- Requested or received HCBS waivers or program services, including IHSS, but were denied or discontinued due to excess property

Example 1: Applicable Application Date for SI Purposes

01/04/2018	Mr. K requests HCBS through waiver administrator.
01/04/2018	Mr. K is placed on a waiver wait list.
01/08/2018	Mr. K submits Medi-Cal application to county.
01/08/2018	County has Mr. K sign Doctor's Verification form and obtains physician's information.
01/17/2018	County receives completed Doctor's Verification form from physician.
Meets level of care 12/01/2017	Doctor's Verification form states that Mr. K meets nursing facility level of care as of 12/01/2017.

In this example, January 4, 2018, is the date of the request for HCBS, and the first month that SI applies is January 2018. The applicable date is not December 1, 2017, when Mr. K met the level of care requirement, because the applicant/beneficiary must meet both the level of care and have made a request for HCBS to trigger the SI provisions.

Example 2: Determining the Applicable Application Date Retroactively (for SI Purposes)

February 2018	Mr. G applies for Medi-Cal and requests HCBS.
February 2018	The CEW sends the Doctor's Verification form to the physician.
April 2018	The county receives the completed Doctor's Verification form. On the Doctor's Verification form, the doctor states that Mr. G began requiring a nursing facility level of care in March 2016.

In this example, the Doctor's Verification form states that Mr. G began requiring a nursing facility level of care in March 2016. The CEW would go back to the first date when both the nursing facility level of care **and** the request for services are present. The request for services is being treated as the application in these retroactive cases. As of February 2018, both the nursing facility level of care and a request for services are present. In this example, February 2018 is the applicable application date. The county would establish eligibility for February 2018 forward, as otherwise eligible.

4. Process for Applying the Spousal Impoverishment Provisions to the HCBS Spouse and Community Spouse

As stated in ACWDL 17-25 and this letter, the SI provisions are a financial methodology applied as an eligibility step in determining eligibility for the Medi-Cal programs in accordance with the Medi-Cal hierarchy. The application of the CSRA pertains to the property determination, as described below. As with all Non-MAGI eligibility determinations, the property determination is completed first, followed by income.

a. Property Determination

The first step of the property eligibility determination is to evaluate which items of property are exempt, unavailable, or countable. Property that is unavailable or exempt does not count towards the CSRA. The combined net non-exempt, available property of both spouses, whether owned jointly or separately, is compared to the applicable CSRA limit plus the $2,000 property limit for one person. Because the HCBS spouse is in a separate Medi-Cal Family Budget Unit (MFBU), the HCBS spouse's property must meet the property limit for one person ($2,000) after the CSRA transfer period.[11]

As described in ACWDL 90-01, Section 50490.7, the CSRA transfer period starts as soon as the initial month of eligibility is established, i.e., the combined non-exempt property of both spouses is under the CSRA plus $2,000. The county must send a NOA granting eligibility and providing the date for the end of the CSRA transfer period. The CSRA period begins with the initial month of SI eligibility and ends on the last day of the month in which the 90th day falls from the NOA issuance date.

At the end of the CSRA transfer period, there is no need for additional verification of nursing facility level of care. The county shall not reevaluate the community spouse's property (the CSRA) or any newly acquired property of the community spouse after the initial month of eligibility has been determined. The CEW must verify that the HCBS spouse has no more than $2,000 of countable property remaining in his or her name.

[11] See ACWDLs 17-25, 91-84, and 90-01 Question and Answer numbers 12, 19, 26, 27 and 29.

This process remains unchanged from the process for determining eligibility using the SI provisions for an institutionalized spouse under ACWDL 90-01. However, there are unique features to these cases. Because many of these cases will be determined retroactively, the CSRA transfer periods may extend for several years (see Diagram 1, which is attached to this letter as Enclosure 7). Counties shall request property verifications only for the applicable application date (the first month the SI provisions apply), unless the countable property exceeds the CSRA plus $2,000. In that circumstance, the county must counsel the applicant about spend-down. In the case of retroactive eligibility, the county must determine which month the property is under the CSRA plus $2,000 (discussed in section 7 below), and request all necessary verifications for that month.

b. Income Calculations

In accordance with ACWDL 17-25, the SI provisions including the spousal income allocation are part of the eligibility determination now rather than institutional deeming.

The income calculations under SI for HCBS are summarized as:

- There is no $35 personal needs allowance
- The spouses are in separate MFBUs even though the HCBS spouse may be in the community, not in an institution
- Use all applicable Non-MAGI program income deductions and disregards
- Apply the Federal Poverty Level limit for one person
- Apply the MN Level for one person
- Spousal and dependent family member income allocations apply.

c. Institutional Deeming

Prior to ACWDL 17-25, under institutional deeming an **otherwise ineligible** spouse was considered as if institutionalized, and the spousal impoverishment provisions were applied, and the approved HCBS waiver or program participant was placed in an MFBU by him or herself. Previously, the SI provisions were applied only after the individual was determined ineligible under all avenues of eligibility and could not be applied until the individual was concurrently approved as an actual HCBS waiver participant.

Now, under ACWDL 17-25, the SI provisions are an eligibility step rather than being included in institutional deeming, as described above. An individual who

meets the criteria to be an HCBS spouse receives the benefit of the SI provisions throughout the consideration of the Non-MAGI hierarchy, even before being placed on a waiting list or actually participating in an HCBS waiver for so long as the request for HCBS is completed and there is no break in the continuous period of institutionalization (see Diagram 2, which is attached to this letter as Enclosure 8). That individual is in a budget unit separate from his/her community spouse once the couple's property meets the CSRA limit plus $2,000 until the end of the continuous period of institutionalization.

It is a common misconception that waiver participants must be eligible under a "waiver aid code." This is erroneous because not all waivers have associated aid codes, nor do all participants require institutional deeming to become eligible. The institutional deeming waiver aid codes apply only for those individuals who require institutional deeming to be eligible.

d. Manual Budgeting

Application of SI provisions requires the use of manual budgets until such time as the State Automated Welfare System (SAWS) programming of the policy changes outlined in this letter and ACWDL 17-25 are complete. When applying the SI provisions to a particular case, the CEW shall retain a copy of the manual budget and complete a journal entry to that effect.

- The journal entry may state, for example: "ACWDL 17-25 was applied to this case. The SI provisions must be applied manually to determine eligibility until the SAWS systems are programmed. See the case file for the completed budget worksheets."
- The county may use the Budget Steps created for this purpose and attached to this letter (see Enclosure 1).

As an alternative, counties may use existing worksheets **with modifications** in determining eligibility under the SI provisions for HCBS.

e. Outreach Flyer

An informational flyer for individuals requesting HCBS waiver services or in-home support is attached to this letter for informational purposes (see Enclosure 3).

5. Ongoing Eligibility

As stated in ACWDL 17-25, once determined eligible using the SI provisions, the HCBS spouse remains eligible, aside from a change in circumstance, unless and until the request for HCBS is denied. The request may be denied because the individual did not meet the clinical standard for the waiver, or the individual is not identified as a CFCO recipient. This will require the county to redetermine eligibility under regular budgeting. A 10-day NOA is required for any adverse action. Changes in circumstance ending the continuous period of institutionalization include: failure to complete the request for HCBS waiver or program or services (see Diagram 2, which is attached to this letter as Enclosure 8), or no longer an inpatient of a medical institution or nursing facility or non-receipt of HCBS waiver or programs services for a full calendar month (ACWDL 90-01, Section 50033.5 of that letter). Changes regarding the HCBS spouse's participation in the HCBS waivers or programs will require communication between the IHSS worker or the waiver administrator/care coordinator and the CEW.

Once the individual becomes an HCBS spouse, he/she begins a continuous period of institutionalization. When the request for HCBS is completed by the HCBS spouse's application for HCBS waiver services or programs or the individual is placed on a waiting list, then the continuous period of institutionalization and the SI provisions shall continue to apply.

If one HCBS waiver or program denies participation to an individual and a second HCBS waiver or program request occurs before the end of a full calendar month after the first waiver denial, then the continuous period has not ended. Eligibility under the SI provisions continues until the county knows the result of the second needs assessment and, if approved, there is no break in the continuous period of institutionalization. The full calendar month requirement before the end of a continuous period, as described in ACWDL 90-01, allows for consideration of an individual's declining health, inpatient admissions, discharges and readmissions, and also allows for the differences between waivers. Each waiver has its own focus and services and an individual may be a better fit under one waiver than another.

At annual renewal, the HCBS spouse, community spouse, beneficiary representative, administrator, or care coordinator need only confirm continued HCBS participation, just as an institutionalized spouse would confirm continued institutionalization on their renewal forms, as long as the period of HCBS participation or institutionalization continues (see section 9 below). There is no need to reverify the nursing facility level of care. The continuous period ends when 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 (see Diagram 3, which is attached to this letter as Enclosure 9).

6. Determining Eligibility for the Community Spouse Who Applies for Medi-Cal Subsequent to the HCBS Spouse's Eligibility

As stated in ACWDL 17-25, if the community spouse applies for Medi-Cal, the community spouse will need to spend down his/her non-exempt countable property to the property reserve limit for one person before the end of the month in which the community spouse is requesting Medi-Cal. The SI provisions continue to apply and a spousal income allocation is still permitted. The couple may adjust the spousal income allocation amount in whatever manner they determine to best preserve the eligibility for each spouse.

If the community spouse also requests HCBS, there is no longer a community spouse. The spouses remain in separate MFBUs and there is no longer a spousal income allocation; however, the division of community property income rules may apply (see Title 22, California Code of Regulations, Sections 50403 and 50404). Part III of the MC 176W Allocation/Special Deduction Work Sheet A also may apply in the case of a PACE/ALW Board and Care spouse who has a CFCO or HCBS spouse residing at home. Finally, court orders for support of the spouse continue to apply (see *Gibbons v. Rank*, ACWDL 87-77).

7. Retroactive Eligibility under the Spousal Impoverishment Provisions for Home and Community-Based Services

Counties must apply the SI provisions retroactively under any of the following circumstances to cases where there is an HCBS spouse:

- At application
- At annual renewal
- Who is a CFCO beneficiary in the 2K aid code[12] with a SOC on or after January 1, 2014 (see below)
- Who is married or an RDP who requested HCBS but was denied or discontinued from Medi-Cal for excess property
- Who requests a retroactive redetermination
- Who requests a fair hearing.

When an individual applies for Medi-Cal and is married or an RDP, the county must review the application to see if in-home assistance/waiver/IHSS services were

[12] Aid code 2K was implemented in September 2014. If the beneficiary was CFCO eligible at any point between January 1, 2014, and September 1, 2014, please contact DHCS Medi-Cal Eligibility Division for assistance in verifying CFCO level of care.

requested or may be needed. If yes, then the CEW must send the Doctor's Verification form. When the completed form is received by the county, the CEW shall apply SI provisions (retroactively if the date of nursing facility level of care and the date of the request for IHSS/HCBS waiver program or services occurred in the past). **Counties must not process current Medi-Cal eligibility and then do retroactive eligibility for Medi-Cal at a later time.** Retroactive eligibility needs to be established before current Medi-Cal eligibility because the CSRA applies once in the initial month of eligibility (see Diagram 1, which is attached to this letter as Enclosure 7).

When annual renewal is approaching and the beneficiary is married or an RDP, the CEW must check the case file to see if HCBS or IHSS services were requested or may be needed. If yes, then the CEW must provide the Doctor's Verification form to the individual for authorization signature, unless the form is in the file already or the beneficiary is already a CFCO participant or HCBS waiver or program participant. CEWs must retroactively apply SI when the completed Doctor's Verification is returned if the date of the nursing facility level of care is retroactive to or after January 1, 2014. (The applicable application date is described in Example 1, above.) The SOC may be lowered upon application of the SI provisions, and this will require reimbursement of out-of-pocket expenses (see discussion below).

If the beneficiary is on a wait list for waiver services, the CEW must provide the Doctor's Verification form to the individual for authorization signature, if a completed one is not already in the file and the beneficiary is not an IHSS-CFCO recipient. The county must be prepared to retroactively apply the SI provisions when the Doctor's Verification form is returned if the date of the nursing facility level of care is retroactive. The SI provisions must be applied for HCBS spouses who requested HCBS on or after January 1, 2014. The CEW must go back to the initial month where there are both a Doctor's Verification form indicating a nursing facility level of care for at least 30 consecutive days and a request for HCBS waiver or program services or the HCBS spouse is on a wait list. The SOC may be lowered upon application of the SI provisions, and this would require reimbursement of out-of-pocket expenses.

CEWs shall review the eligibility of current CFCO recipients in the CFCO aid code 2K with a SOC on or after January 1, 2014. A Doctor's Verification form is not required in these cases. SI provisions apply back to the month in which the individual became a 2K CFCO participant. Aid code 2K was implemented in September 2014. If the beneficiary was CFCO eligible at any point between January 1, 2014, and September 1, 2014, please contact DHCS Medi-Cal Eligibility Division for assistance in verifying CFCO level of care.

When counties become aware of married individuals or RDPs who requested HCBS but were denied or discontinued Medi-Cal due to excess property, the CEWs must complete retroactive determinations. **Individuals do not need to reapply for Medi-Cal. Use the application and verification of income and property provided at that time. If eligible, the CSRA transfer period extends from the initial month of eligibility forward.** The Doctor's Verification form is required to establish when the individual first required a nursing facility level of care. If eligible, the denials or discontinuances due to excess property must be rescinded and any SOC must be adjusted retroactively as far back as January 1, 2014. The times when counties may become aware of such individuals include, but are not limited to: annual renewals, fair hearings, and retroactive redetermination requests.

Apply the SI provisions as of the earliest date when **both** of the following requirements are met:

- HCBS or IHSS is requested, **and**
- Nursing facility level of care based on the Doctor's Verification form or an already completed needs assessment for a CFCO recipient.

Some retroactive claims may go back months or years. When doing retroactive SI calculations, the county does not need to go through every month and obtain verifications for all property for every month. Instead, the county can interview the couple and narrow down the focus by looking first at those months with significant property events. Then obtain property verification documents for those months to see when eligibility can be established. The CEW must move forward in time from those months until there is a month where the couple met the CSRA plus $2,000 limit. Once the county is able to pinpoint the initial month of eligibility when the couple meets the CSRA plus $2,000, then it must obtain the appropriate income verifications for that month.

The transfers of property rules do not apply to SI cases under HCBS. In addition, transfers of property at any time to the spouse or RDP are protected and do not result in periods of ineligibility. However, at the end of the CSRA transfer period, property held in the name of the HCBS spouse, individually or jointly, cannot exceed the $2,000 property limit for one person. Before the end of the CSRA transfer period, any excess property may be transferred to the community spouse or spent down. The CSRA transfer period ends on the last day of the month that includes the 90th day from the date that the eligibility NOA is issued. (See ACWDL 90-01, Sections 50490.3 and 50490.7 of that letter). The CSRA determination occurs only in the initial month of eligibility, and then the CSRA transfer period begins (see Diagram 1, which is attached to this letter as Enclosure 7).

Where a case has been transferred from one county to another and the receiving county finds that it must apply the SI provisions retroactively, the two counties must work together. The SI provisions must be applied manually, until programmed into SAWS, and the counties must complete online Medi-Cal Eligibility Data System transactions. The current aid code will remain in place while the SOC and other retroactive calculations are completed.
For a case example in which the SI provisions are applied retroactively back several years, see Example 3 attached to this ACWDL as Enclosure 6.

Example 4: CSRA Transfer Period

January 2018	Mr. M applies for Medi-Cal and requests HCBS.
February 2018	The CEW sends the Doctor's Verification form to the physician.
April 2018	The county receives the completed Doctor's Verification form.
	On the Doctor's Verification form, the doctor states that Mr. M began requiring a nursing facility level of care in January 2018.
May 1, 2018	The county issues a NOA granting Mr. M eligibility back to March 2018, when the couple met the CSRA plus $2,000 property limit.

In this example, the CEW evaluates January 2018, when Mr. M meets the two criteria for the SI provisions to apply. Mr. M is over the CSRA plus $2,000 limit for the entire month of January, so the CEW evaluates February 2018. Mr. M again is over the limit for the entire month of February. Mr. M met the CSRA plus $2,000 limit in March 2018. Mr. M's eligibility is established for March 2018 and he can submit claims for reimbursement for out-of-pocket expenses incurred in March 2018 and April 2018. The CEW is required to process the retroactive eligibility for March 2018 as the initial month and ongoing from that month. The CSRA transfer period begins on March 1, 2018, and extends through August 31, 2018.

8. Retroactive Reimbursement under the Beneficiary Reimbursement Process

To submit Medi-Cal claims for reimbursement under the Beneficiary Reimbursement Process (also known as the Conlan process),[13] the beneficiary calls the Beneficiary Services Center (BSC) at (916) 403-2007.[14] The BSC provides the beneficiary with the necessary forms and instructions for filing a claim for reimbursement.

[13] As the result of a court order issued on November 17, 2006, in the litigation entitled *Conlan v. Shewry*, Medi-Cal can reimburse beneficiaries for covered medical and/or dental expenses that have been paid.
[14] The TDD phone number is (916) 635-6491.

IHSS reimbursement claims are initiated by the beneficiary through the BSC. When IHSS claims are submitted to the BSC, they are routed to the California Department of Social Services for adjudication. A beneficiary may be reimbursed only for services provided by an enrolled IHSS provider. A beneficiary may be reimbursed for services provided by an IHSS enrolled provider as far back as January 1, 2014, if eligible for IHSS back to January 1, 2014.

Timeframes under the Beneficiary Reimbursement Process follow those mandated by the Conlan court order. For additional information on the Beneficiary Reimbursement Process, see the list of County Resources for Beneficiary Reimbursement Process (aka Conlan Process) attached to this ACWDL as Enclosure 4 or refer to the DHCS website.

9. Overview of the Annual Renewal Process

Annual renewal, or annual redetermination, provides opportunities for counties to provide HCBS SI information to the beneficiaries. Information can be shared in the following ways:

- Counties can include a special message[15] about the HCBS SI provisions in the annual renewal packet (MC 210 RV)
- During the "one contact," the CEW can ask married individuals if they need in-home assistance or if they are on an HCBS wait list. If the CEW must leave a voice mail message, the CEW can ask the individual to call back for rescreening, and/or
- Counties can add a brief message[16] to the NOA when adverse NOAs or SOC NOAs are issued.

When counties review cases to see if the SI provisions apply, the CEW follows the standard renewal processes to verify property. If the individual is married or an RDP, is on a waiver wait list and the individual has not yet received an assessment by the

[15] Suggested language will be provided to the counties in a subsequent MEDIL.
[16] Suggested language is: "Please Note: If you are on a wait list for a Home and Community-Based Services (HCBS) waiver or program, special Medi-Cal eligibility rules (called spousal impoverishment) may apply to you. Special Medi-Cal eligibility rules may apply if you are married or in a registered domestic partnership, meet the medical requirements, and have requested HCBS. You may be eligible for Medi-Cal and Medi-Cal covered services while you wait. You must apply and be approved for Medi-Cal to get services while you wait for the waiver services you asked for. Please call your county worker if you need additional information about this."

waiver program or IHSS, the CEW must forward the Doctor's Verification form. Any request for HCBS triggers the Doctor's Verification process unless there already has been a needs assessment for a waiver program or CFCO.

The individual's request for services plus the nursing facility level of care will trigger the applicable application date for SI provisions. The date is the earliest date where **both** of the following are met:

- HCBS or IHSS has been requested, **and**
- The individual requires a nursing facility level of care established by the Doctor's Verification form or through a needs assessment by the HCBS waiver or program.

This applies even when the applicable date for the SI provisions occurred months or years previously. In that case, the SI provisions must be applied retroactively (as far back as January 1, 2014).

If the HCBS spouse acquired new property (e.g., an inheritance), one option is for him/her to transfer it to the community spouse (see ACWDL 90-01, Section 50411.5 of that letter). Another option is for him/her to spend it down or convert it (see Title 22, California Code of Regulations, Sections 50406 and 50407).

As stated in ACWDL 17-25, **once eligibility under the SI provisions has been established, CEWs shall not recalculate the CSRA, verify the property of community spouses, or verify nursing facility level of care again at annual renewal**. The HCBS spouse and the community spouse remain in separate budget units. The CEWs redetermine the HCBS spouse's eligibility by verifying that the HCBS spouse has no more than $2,000 in his/her own name and then meets income eligibility requirements. In addition, when SI cases come up for annual review, the institutionalized spouse, HCBS spouse, community spouse or authorized representative simply indicates in the renewal packet that the individual continues to receive HCBS waiver or program services or inpatient services in a medical institution or nursing facility.

Implementation Timeline

SAWS shall make programming changes to automate these SI provisions for HCBS during the next available SAWS release. In the meantime, counties must complete these determinations and budgeting manually and document them in the case file. DHCS will continue to work with SAWS to facilitate the programming of the SI provisions, including budgeting for the HCBS population.

If you have questions regarding this letter, please contact Barbara Schmitz at

(916) 345-8070 or by email at Barbara.Schmitz@dhcs.ca.gov, or Phoua Moua at (916) 345-8064 or by email at Phoua.Moua@dhcs.ca.gov, or Sharyl Shanen-Raya at (916) 345-8066 or by email at Sharyl.Shanen-Raya@dhcs.ca.gov.

Original Signed By

Sandra Williams, Chief
Medi-Cal Eligibility Division

Enclosures (9)

Case Name: **Case Number:**

Current Date: **Month of Eligibility:**

Budget Steps for HCBS Spousal Impoverishment

STEP 1 – DETERMINE POTENTIAL SPOUSAL INCOME ALLOCATION

	Potential Spousal Income Allocation	Community Spouse
	Gross Income	
1	SSA	
2	Property Net Income	
3	In-Kind Income	
4	Other Unearned Income (identify)	
5	Other Unearned Income (identify)	
6	Gross Earned Income	
7	**Subtotal Gross Income** (Add Lines 1 through 6 and enter the result here)	
8	Enter Medicare and OHC Premiums*	–
9	**Total Gross Income** (Subtract Line 8 from Line 7 and enter the result here)	
10	Enter the MMMNA Standard Amount	
11	Enter Total Gross Income from Line 9	–
12	**Amount of Potential Spousal Income Allocation** (Subtract Line 11 from Line 10 and enter the result here) • If result is = < 0, then there is no potential spousal income allocation, unless… (see note below). • If the result is > 0, then the result is the spousal income allocation, unless… (see note below). NOTE: If a fair hearing or a court order for support has established a greater spousal income allocation or a spousal support amount, then the ordered amount shall be deducted from the HCBS spouse's income.	

- If the community spouse applies for Medi-Cal and has Medicare, when Buy-In occurs for the community spouse, counties will potentially need to recalculate eligibility for the HCBS spouse due to the change in the spousal income allocation. Therefore, when Buy-In occurs for the community spouse, simply enter zero for Medicare premium amount.

Case Name: **Case Number:**

Current Date: **Month of Eligibility:**

STEP 2 – DETERMINE HCBS SPOUSE'S ELIGIBILITY FOR ABD FPL

		HCBS Spouse	
	Unearned Income		
1	SSA		
2	Property Net Income		
3	In-Kind Income		
4	Other Unearned Income (identify)		
5	Other Unearned Income (identify)		
6	**Total Unearned Income** (Add Lines 1 through 5 and enter the result here)		
7	Enter Any Income Deduction ($20)	–	
8	**Countable Unearned Income** (Subtract Line 7 from Line 6 and enter the result here)		
	Earned Income		
9	**Gross Earned Income**		
10	Enter Earned Income Deduction ($65)	–	
11	Enter Unused $20 Any Income Deduction	–	
12	Remaining Earned Income (Subtract Line 10 and 11 from Line 9 and enter result here)		
13	Divide Remaining Earned Income by 2 and enter result here	–	
14	**Countable Earned Income** (Subtract Line 13 from Line 12 and enter result here)		
15	**Total Countable Unearned and Earned Income** (Add Line 8 and Line 14 and enter the result here)		
16	Enter the ABD FPL Standard Deduction for one ($230)	–	
17	Enter Medicare and OHC Premiums - Buy-In is predicted to occur in the third month from the current month	Pre-Buy-In –	Post Buy-In –
18	If a fair hearing order or a court order for support sets a spousal income allocation that is greater than the spousal income allocation calculated in Step 1, enter that amount here. If not, enter 0.	–	
19	**Net Nonexempt Income** (Subtract Lines 16 through 18 from Line 15 and enter the result here)	Pre-Buy-In	Post Buy-In
20	Enter 100% FPL for one person	–	
21	Subtract Line 20 from Line 19 and enter the result here. • **If result = 0 or < 0, then the HCBS spouse is eligible.** If there was no amount entered in Line 18 above as set by Fair Hearing or Court Order, there is nothing available to allocate.	Pre-Buy-In ☐ Eligible	Post Buy-In ☐ Eligible

Case Name: **Case Number:**

Current Date: **Month of Eligibility:**

	• If result is > 0 and there was no amount entered in Line 18 above as set by Fair Hearing or Court Order, then the result is **Excess Income**. **Proceed to Line 22.** • If the result is > 0 and there was an amount entered in Line 18 above as set by Fair Hearing or Court Order, then the result is **Excess Income. Proceed to and enter the result in Line 23.**		
22	Enter the amount of the potential spousal income allocation calculated in Step 1 here	–	
23	**Excess Income** (Subtract Line 22 from Line 21 and enter the result here, unless entering Excess Income directly from Line 21). • **If result = 0 or < 0, then HCBS spouse is eligible.** • **If the result is >0 and there are:** **- No dependent family members residing with the community spouse, proceed to Step 3** on page 4. • **If the result is >0 and there are:** **- Dependent family members residing with the community spouse, proceed to Line 24.**	Pre-Buy-In ☐ Eligible	Post Buy-In ☐ Eligible
24	Enter Maximum Allocation Base		
25	Enter the number of dependent family members residing with the community spouse	**X**	
26	Multiply Line 24 by Line 25 and enter the result here		
27	Enter Total Gross Income of all dependent family members identified in Line 25	–	
28	**Potential Family Member Allocation –** Subtract Line 27 from Line 26 and enter the result here		
29	Enter **Excess Income** from Line 23	Pre-Buy-In	Post Buy-In
30	Enter potential family member allocation from Line 28	–	
31	Remainder (Subtract Line 30 from Line 29 and enter result here). • **If the remainder is = 0 or < 0, then the HCBS spouse is eligible.** The Excess Income from Line 29 equals the **Total Family Member Allocation**. The spouses will need to decide how to divide the family member allocation between any family members who also apply. • **If the remainder is > 0, then go to Step 3** on page 4.	Pre-Buy-In ☐ Eligible	Post Buy-In ☐ Eligible

Case Name: **Case Number:**

Current Date: **Month of Eligibility:**

Step 3 – 250% Working Disabled Program

Complete only if the HCBS spouse is working. If not working, move to Step 4.

		HCBS Spouse	
1	Enter **Total Unearned Income** from Step 2, Line 6		
2	Enter Disability Income (this includes SSDI and Title II Retirement Income that used to be SSDI)	–	
3	Enter Any Income Deduction $20	–	
4	**Countable Unearned Income** (Subtract Lines 2 and 3 from Line 1 and enter the result here)		
5	Enter **Gross Earned Income** from Step 2, Line 9		
6	Enter Impairment-Related Work Expenses (IRWEs)	–	
7	Enter Earned Income Deduction ($65)	–	
8	Remainder (Subtract Lines 6 and 7 from Line 5 and enter result here)		
9	Divide Remainder by 2 (divide Line 8 by 2 enter result here)	–	
10	**Countable Earned Income** (Subtract Line 9 from Line 8 and enter result here)		
11	**Subtotal Countable Earned and Unearned Income** (Add Line 4 and Line 10 and enter result)		
12	Enter Medicare and OHC Premiums - Buy-In is predicted to occur in the third month from the current month	Pre-Buy-In –	Post-Buy-In –
13	**Total Countable Earned and Unearned Income** (Subtract Line 12 from Line 11 and enter result here)	Pre-Buy-In	Post-Buy-In
14	If a fair hearing order or a court order for support sets a spousal income allocation that is greater than the potential spouse income allocation calculated in Step 1, enter that amount here. If not, enter 0.	–	
15	**Net Nonexempt Income** (Subtract Line 14 from Line 13 and enter result here). Calculate premium based upon this amount.	Pre-Buy-In	Post-Buy-In
16	Enter 250% FPL for one person	–	
17	Subtract Line 16 from Line 15 and enter result here • **If result = 0 or is < 0, then the HCBS spouse is eligible**. If there was no amount entered in Line 14 above as set by Fair Hearing or Court Order, there is nothing available to allocate. • If result is > 0 and there was no amount entered in Line 15 above as set by Fair Hearing or Court Order, then the result is **Excess Income. Proceed to Line 18.** • If the result is > 0 and there was an amount entered in Line 14 above as set by Fair Hearing or Court Order, then the	Pre-Buy-In ☐ Eligible	Post-Buy-In ☐ Eligible

Case Name: **Case Number:**

Current Date: **Month of Eligibility:**

	result is **Excess Income. Proceed to and enter the result in Line 19.**		
18	Enter the potential spousal income allocation if there was no fair hearing or court order calculated in Step 1 here	**–**	
19	**Excess Income** (Subtract Line 18 from Line 17 and enter the result here, unless entering Excess Income directly from Line 17). • **If result = 0 or < 0, then HCBS spouse is eligible.** • **If the result is >0 and there are:** **- No dependent family members residing with the community spouse, proceed to Step 4** on page 6. • **If the result is >0 and there are:** **- Dependent family members residing with the community spouse, proceed to Line 20.**	Pre-Buy-In ☐ Eligible	Post-Buy-In ☐ Eligible
20	Enter Maximum Allocation Base		
21	Enter the number of dependent family members residing with the community spouse	**X**	
22	Multiply Line 20 by Line 21 and enter the result here		
23	Enter Total Gross Income of all dependent family members identified in Line 21	**–**	
24	**Potential Family Member Allocation –** Subtract Line 23 from Line 22 and enter result here		
25	Enter **Excess Income** from Line 19	Pre-Buy-In	Post Buy-In
26	Enter potential family member allocation from Line 24	**–**	
27	Remainder (Subtract Line 26 from Line 25 and enter result here) • **If the remainder is = 0 or < 0, then the HCBS spouse is eligible.** The Excess Income from Line 25 equals the **Total Family Member Allocation**. The spouses will need to decide how to divide the family member allocation between any family members who also apply. • **If the remainder is > 0, then go to Step 4** on page 6.	Pre-Buy-In ☐ Eligible	Post Buy-In ☐ Eligible

Case Name: **Case Number:**

Current Date: **Month of Eligibility:**

STEP 4 – Medically Needy Program

		HCBS Spouse	
1	Enter **Total Countable Unearned and Earned Income** from Step 2, Line 15		
2	Enter Income Used to Determine Public Assistance Eligibility	–	
3	Enter Medicare and OHC Premiums - Buy-In is predicted to occur in the third month from the current month	Pre-Buy-In –	Post Buy-In –
4	If a fair hearing order or a court order for support sets a spousal income allocation that is greater than the potential spouse income allocation calculated in Step 1, enter that amount here. If not, enter 0.	–	
5	**Net Nonexempt Income** (Subtract Lines 2 through 4 from Line 1 and enter the result here)	Pre-Buy-In	Post Buy-In
6	Enter $600 MNL for one person	–	
7	Subtract Line 6 from Line 5 and enter result here • **If result is = 0 or < 0, then the HCBS spouse is eligible**. If there was no amount entered in Line 4 above as set by Fair Hearing or Court Order, there is nothing available to allocate. • If result is > 0 and there was no amount entered in Line 4 above as set by Fair Hearing or Court Order, then the result is **Excess Income**. Proceed to Line 8. • If the result is > 0 and there was an amount entered in Line 4 above as set by Fair Hearing or Court Order, then the result is **Excess Income.** Proceed to and enter the result in Line 9.	Pre-Buy-In ☐ Eligible	Post Buy-In ☐ Eligible
8	Enter the amount of the potential spousal income allocation calculated in Step 1 here	–	
9	**Excess Income** (Subtract Line 8 from Line 7 and enter the result here, unless Excess Income was entered directly from Line 7). • If result is = 0 or < 0, then HCBS spouse is eligible and there is **Zero Share of Cost (SOC)**. • If the result is > 0 and there are: - No dependent family members residing with the community spouse, then the HCBS spouse is eligible and the result is the **SOC.** - Dependent family members residing with the community spouse, proceed to Line 10.	Pre-Buy-In ☐ Eligible	Post Buy-In ☐ Eligible
10	Enter Maximum Allocation Base		
11	Enter the number of family members residing with the community spouse	**X**	

Case Name: **Case Number:**

Current Date: **Month of Eligibility:**

12	Multiply Line 10 by Line 11 and enter the result here		
13	Enter Total Gross Income of all dependent family members identified in Line 11	–	
14	**Potential Family Member Allocation –** Subtract Line 13 from Line 12 and enter result here		
15	Enter **Excess Income** from Line 9	Pre-Buy-In	Post-Buy-In
16	Enter potential family member allocation from Line 14	Pre-Buy-In –	Post-Buy-In –
17	Remainder is **SOC** (Subtract Line 16 from Line 15 and enter result here) • **If the remainder is = 0 or < 0, then the HCBS spouse is eligible** with a **Zero SOC**. The Excess Income from Line 9 equals the **Total Family Member Allocation**. The spouses will need to decide how to divide the family member allocation between any family members who also apply. • **If the remainder is > 0, then the remainder is the SOC**. The HCBS spouse is eligible with a **SOC** and there will be no Medicare Part B Buy-In. **NOTE**: Remember that a Board and Care (B&C) deduction may apply for individuals who are in the assisted living or board and care rather than receiving services in their own homes. The B&C deduction may zero out the remaining SOC. (See Title 22, CCR, Section 50515(a)(3) and ACWDL 00-56.	Pre-Buy-In ☐ Eligible	Post-Buy-In ☐ Eligible

California's 1915(c) Home and Community-Based Services (HCBS) Waivers

Waiver Name	Operated By	Target Population	Service Area
Assisted Living Waiver (ALW)	DHCS	Aged, Disabled, 21 and over	15 Counties
HCBS Waiver for Individuals with Developmental Disabilities (DD)	CDDS	Individuals with Intellectual or Developmental Disabilities, all ages	Statewide
HIV/AIDS	CDPH	Individuals with HIV/AIDS, all ages	Statewide*
Home and Community-Based Alternatives (HCBA) Waiver	DHCS	Aged, Disabled, all ages	Statewide
In-Home Operations (IHO) Waiver	DHCS	Aged, Disabled, all ages	Statewide
Multipurpose Senior Services Program (MSSP)	CDA	Aged, 65 and older	Statewide*
Pediatric Palliative Care (PPC) Waiver	DHCS	Medically fragile, under 21	12 counties

*The state has the authority to operate these waivers statewide, however, availability of services is dependent on provider availability. The table below lists counties where providers are available as of the date of this resource.

County	ALW	DD	HCBA	HIV/AIDS	IHO	MSSP	PPC
Alameda	X	X	X	X	X	X	X
Alpine		X	X		X	X	
Amador		X	X		X	X	
Butte		X	X	X	X	X	
Calaveras		X	X		X	X	
Colusa		X	X	X	X		
Contra Costa	X	X	X	X	X	X	
Del Norte		X	X		X		
El Dorado		X	X	X	X	X	
Fresno	X	X	X		X	X	X
Glenn		X	X	X	X	X	
Humboldt		X	X		X	X	
Imperial		X	X		X	X	
Inyo		X	X		X		
Kern	X	X	X		X	X	
Kings		X	X		X	X	
Lake		X	X	X	X	X	
Lassen		X	X		X	X	
Los Angeles	X	X	X	X	X	X	X
Madera		X	X		X	X	
Marin		X	X		X	X	X
Mariposa		X	X		X	X	
Mendocino		X	X	X	X	X	
Merced		X	X		X	X	
Modoc		X	X		X	X	
Mono		X	X		X		
Monterey		X	X		X	X	X
Napa		X	X		X	X	
Nevada		X	X	X	X		

California's 1915(c) Home and Community-Based Services (HCBS) Waivers

County	ALW	DD	HCBA	HIV/AIDS	IHO	MSSP	PPC
Orange	X	X	X	X	X	X	X
Placer		X	X	X	X	X	
Plumas		X	X		X		
Riverside	X	X	X	X	X	X	
Sacramento	X	X	X	X	X	X	
San Benito		X	X		X		
San Bernardino	X	X	X	X	X	X	
San Diego	X	X	X		X	X	
San Francisco	X	X	X	X	X	X	X
San Joaquin	X	X	X		X	X	
San Luis Obispo		X	X	X	X		
San Mateo	X	X	X		X		
Santa Barbara		X	X		X	X	
Santa Clara	X	X	X		X	X	X
Santa Cruz		X	X	X	X	X	X
Shasta		X	X	X	X	X	
Sierra		X	X		X		
Siskiyou		X	X		X	X	
Solano		X	X		X	X	
Sonoma	X	X	X	X	X	X	X
Stanislaus		X	X	X	X	X	
Sutter		X	X	X	X		
Tehama		X	X	X	X	X	
Trinity		X	X	X	X	X	
Tulare		X	X		X	X	
Tuolumne		X	X		X	X	
Ventura		X	X	X	X	X	
Yolo		X	X	X	X	X	
Yuba		X	X	X	X	X	

Resources/Referral Information:

Program	Referral Information
ALW	Contact a Care Coordination Agency. A list is available on the DHCS website: http://www.dhcs.ca.gov/
DD	Contact the local Regional Center. A list is available on the DDS website: http://www.dds.ca.gov/
HIV/AIDS	Contact a local AIDS Medi-Cal Waiver Program. A list is available on the CDPH website: https://www.cdph.ca.gov/
HCBA	Integrated Systems of Care Division, DHCS: 916-552-9105; The program application is available on the DHCS website: http://www.dhcs.ca.gov/
IHO	Integrated Systems of Care Division, DHCS: 916-552-9105
MSSP	Contact local MSSP Site. A list is available on the CDA website: http://www.aging.ca.gov/
PPC	Contact local CCS County office. A list is available on the DHCS website: http://www.dhcs.ca.gov/

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

1915(c) Home and Community-Based Services (HCBS) Waiver Programs

Thank you for your interest in one of our HCBS programs. Read this flyer to learn more.

What to do next

If you are on a wait list for an HCBS waiver or program, special Medi-Cal eligibility rules called "spousal impoverishment" may apply to you. The rules may apply if you:

- Are married or in a registered domestic partnership
- Meet the medical requirements **and**
- Have asked for HCBS.

To get the waiver services you asked for, you must **apply** and **be approved** for Medi-Cal once a space is open for you. You can apply at your local county Medi-Cal office. Or you can apply online, by mail or by phone.

To learn more about applying and to see the Medi-Cal office list, visit the Department of Health Care Services (DHCS) website at http://www.dhcs.ca.gov.

When you apply for Medi-Cal

- Show this flyer to your local county Medi-Cal office. Or tell them you got this flyer.
- The county will contact you if they need more information.
- The county may ask you to sign a Doctor's Verification form. This is so they can get information from your doctor. Your doctor's information may show that you meet the medical requirements for the special eligibility rules. If so, the county will check to see if you qualify for Medi-Cal with no cost or a lower share of cost. It does **not** guarantee that you qualify for Medi-Cal or meet the special eligibility rules.
- You must qualify for Medi-Cal and have a separate physical evaluation before you can be in Medi-Cal's HCBS waivers or programs.

For questions or to learn more about how you may qualify for Medi-Cal, please contact your local county Medi-Cal office.

To be filled out by Waiver Administrator

Name of individual requesting HCBS: _____

Date individual requested HCBS: _____

Waiver Administrator name: _____

Waiver Administrator contact (name and phone): _____

County Resources for Beneficiary Reimbursement Process (Conlan Process)

The following resources are available on-line:

1. **Medi-Cal Out-of-Pocket Expense Reimbursement (Conlan)**

2. **All County Welfare Directors Letter (ACWDL) 07-01:** Notice to counties on a mass mailer sent to beneficiaries as a result of the Conlan lawsuit.

3. **ACWDL 07-02:** Notice to counties on a poster that counties are required to put up in their Medi-Cal offices for beneficiaries to read about *Conlan v. Bontá* and *Conlan v. Shewry*

4. **California Department of Social Services (CDSS) website on the In-Home Supportive Services (IHSS) and Conlan Processes**

5. **All County Information Notice I-03-10 (January 21, 2010):** Conlan II Reimbursement Process

6. **All County Letter (ACL) 09-48 (September 18, 2009):** Policy Change Regarding X-27 Spec Transactions in the Case Management Information and Payrolling System (CMIPS)

7. **ACL 09-47 (September 16, 2009):** Statutory Changes in the California Department of Social Services' Program for Payment of Medical Recognized Expenses (Otherwise Known as the Share-Of-Cost Buyout Program), Including Its Elimination Effective October 1, 2009

8. **ACL 09-27 (May 28, 2009):** Statutory Change in California Department of Social Services' Program for Payment of Medi-Cal Recognized Expenses (Buyout Program)

9. **ACL 07-32 (September 13, 2007):** Additional Claims to Be Submitted Through the Conlan II Claims Process

10. **ACL 07-11 (February 20, 2007):** Implementation of Conlan II Court Order: Reimbursement of Covered Services for In-Home Supportive Services (IHSS) Recipients

11. **For more information or to file a claim, please call or write to Medi-Cal:**
    California Department of Health Care Services / Beneficiary Services Center
    P.O. Box 138008
    Sacramento, CA 95813-8008
    Phone: (916) 403-2007 TDD: (916) 635-6491

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Reminder: Instructions when Completing an MC 604 MDV Form

June 5, 2018

Providers should complete the *Doctor's Verification for Home and Community Based Services Under Spousal Impoverishment Provisions*, also known as the Medi-Cal Doctor's Verification form (MC 604 MDV), in a timely manner upon receipt from the county, patient or patient's representative, in order to verify the nursing facility level of care that may allow a patient to qualify for in-home care and support services. To properly complete the form, providers must fill in the *Doctor's Information* section of the form and submit the completed form to the county in the preaddressed envelope, if provided.

The MC 604 MDV form is used for Medi-Cal eligibility purposes and is separate from the assessment required by In-Home Support Services (IHSS) or other waiver programs.

[This NewsFlash is located on the DHCS website.]

Example 3: Spousal Impoverishment Provisions Applied Retroactively

In 2015, Mrs. S requests Home and Community Based Services waiver services and Medi-Cal. The Spousal Impoverishment provisions are not used in the evaluation and she is approved for Medi-Cal with a share of cost. In 2018, the county must apply the Spousal Impoverishment provisions retroactively back to 2015.

5/3/2015	Mrs. S requests Home and Community Based waiver services.
5/5/2015	Mrs. S submits Medi-Cal application (approved with share of cost).
6/15/2015	Placed on waiver wait list.
	While on waiver wait list, Mrs. S requested In-Home Supportive Services.
2/2018	County received Doctor's Verification Form—applicant meets nursing facility level of care back to 4/1/2015.
5/1/2015	Applicable application date.

Property

The chart below shows the property evaluation completed on the initial application.

Mrs. S (HCBS)—age 73	**Community Property (5/2015)**	**Mr. S (Community)—age 75**
Individual Retirement Account (IRA)	Principal residence	Individual Retirement Account (IRA)
Wedding and engagement rings	Vehicle	Wedding ring
	Savings account	
	Checking account	
	Irrevocable burial trust with 2 life insur. policies and 2 burial plots.	

Property Valuation and Status (5/2015)

Look at availability and exemptions to determine what is countable. Values are not needed for exempt property, unless there is a reason to verify the value(s) to exempt it.

Principal residence	-----	Exempt
Irrevocable burial trust	$20,000 life insurance (2) $10,000 burial plot (2)	Exempt
Mrs. Individual Retirement Account (IRA)	$80,000	Unavailable (Required Minimum Distribution for those aged 70½ and over)
Checking account	$600	Countable
Savings account	$1,000	Countable
Wedding and engagement rings	$2,000	Exempt
Mr. Individual Retirement Account (IRA)	----	Exempt (non-applicant spouse)
Vehicle	$18,000	Exempt (only vehicle)

Countable Property (Regular Analysis, not Spousal Impoverishment)

The evaluation occurred first under regular Medi-Cal rules.

Checking	$600
Savings	$1,000
TOTAL	$1,600
	NO EXCESS PROPERTY

Reported Income and Deductions (5/2015)

Mrs. S (HCBS Spouse)			**Mr. S (Community Spouse)**	
Social Security retirement	$900		Social Security retirement	$1,300
Required Minimum Distribution of Individual Retirement Acct.	$500		Required Minimum Distribution of Individual Retirement Account	$800
Total	$1,400		Total	$2,100
Subtract health care premium $109 (2015)	−$109		Subtract health care premium $109 (2015)	−$109
Total	**$1,291**		**Total**	**$1,991**
Original Aged & Disabled Federal Poverty Level 2015 Calculation for Two				
Monthly income ($1,400 + 2,100)	$3,500			
Subtract Medicare premiums (both spouses)	−$218			
Subtract Any Income deduction $20	−$20			
Subtract Aged & Disabled Federal Poverty Level standard deduction for two $310	−$310			
Total	**$2,952**			
Compare to 100% Federal Poverty Level limit of $1,638 (2015) ($1,328 + $310 spouse)				
Result: Ineligible				
Original Medically Needy 2015 Calculation for Two				
Monthly income	$3,500			
Subtract Any Income deduction $20	−$20			
Subtract Medicare premiums (both spouses)	−$218			
Total	**$3,262**			
Subtract MN level for 2 adults	−$934			
Result: $2,328 Share of Cost				

Discussion: In the present day, the county must review the original eligibility determination. At that time, this couple's property reserve was $1,600 (under the $3,000 limit for 2 people). At the end of the Community Spouse Resource Allowance transfer period, Mrs.' property will need to be under $2,000 for one person. If Mrs.' property is over, she will have to transfer property to Mr. or spend down.

Analysis: Now the county finds that it must go back and do a Spousal Impoverishment analysis on this couple. This is a manual process. Look at the income for 2015, look at the spousal income allocation, and separate the spouses into separate Medi-Cal Family Budget Units. First, evaluate her under the Aged & Disabled Federal Poverty Level Program in a budget unit of **one**, using the 100% Federal Poverty Level limit for **one** (2015) and the income disregard for **one** person. This applicant/beneficiary does not need to transfer any property during the Community Spouse Resource Allowance transfer period because she is under the $2,000 property limit for one person.

What is the applicable application date? 05/03/2015.
What is the first month that Spousal Impoverishment applies? 05/2015.

Spousal Impoverishment Provisions Applied Retroactively

In present day, complete the Spousal Impoverishment analysis back to 5/1/2015. Use separate Medi-Cal Family Budget Units.

Income and Deductions (Spousal Impoverishment Analysis)
(5/2015)

Mrs. S (HCBS Spouse)			**Mr. S (Community Spouse)**	
Income	$1,400		Income	$2,100
Subtract Medicare premium	−$109		Subtract Medicare prem.	−$109
Total	$1,291		Total	$1,991
Subtract Any Income deduction $20	−$20		Compare to 2015 MMMNA $2,981	
Subtract Aged & Disabled Federal Poverty Level standard deduction for one $230	−$230		**Potential** spousal allocation	$990
Subtract Aged & Disabled Federal Poverty Level for one ($981 for 2015)	-$981			
Subtract **actual** spousal income allocation	-$60			
Total	**$0**			
Result: Eligible				

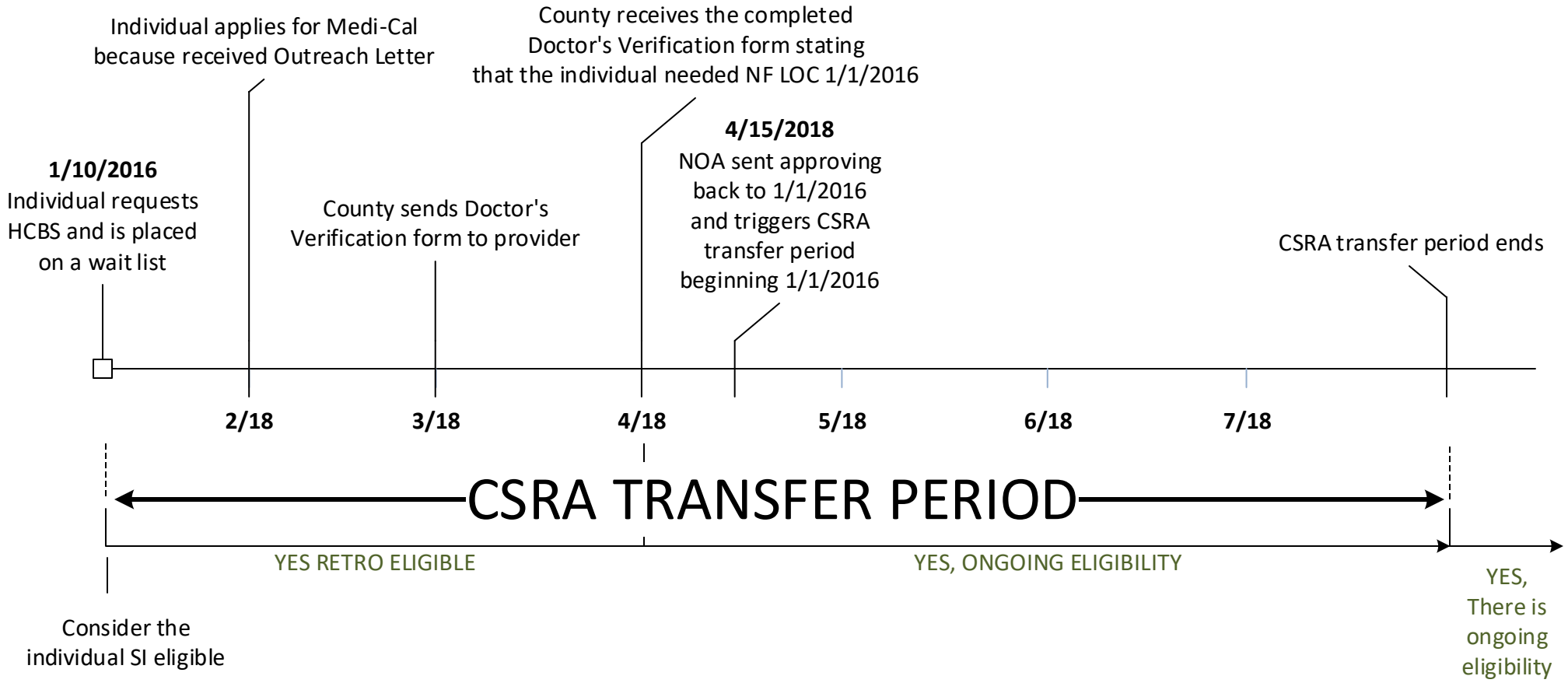
Discussion: The county will need to repeat this for 2016 and 2017 unless there is a change to Mr. S and Mrs. S' circumstances.

What happens if the county is missing verification for applicable months in this example? How many chances are there for the beneficiary to provide the missing verification? Keep working with the client.

Enclosure 7

Diagram 1

CSRA Transfer Period



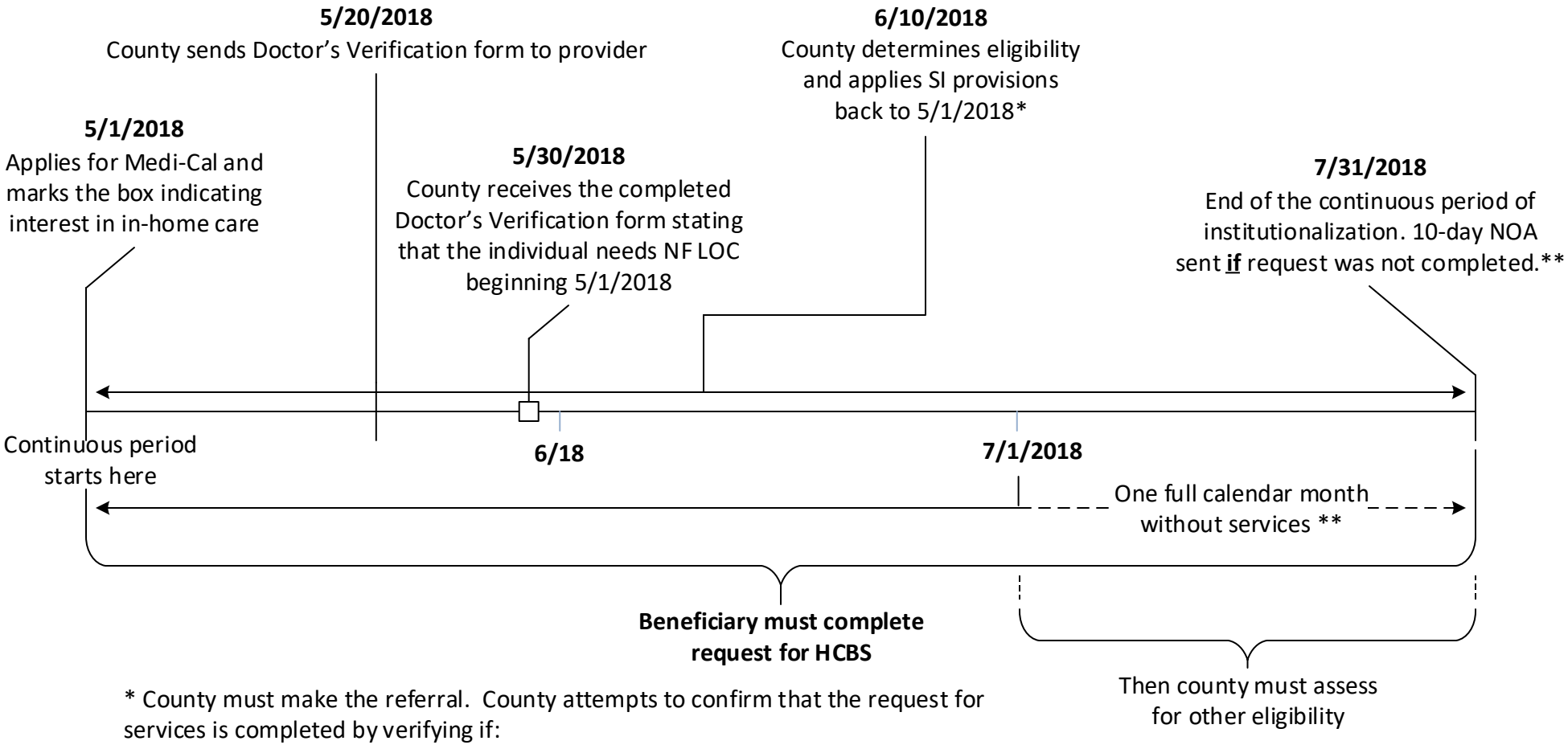
Enclosure 7

Diagram 1

This diagram demonstrates how the CSRA Transfer Period operates when the county applies the SI provisions retroactively to the applicable application date. On1/10/2016, individual requests HCBS and is placed on a wait list. On 2/18, individual applies for Medi-Cal because received Outreach Letter. On 3/18, county sends Doctor's Verification form to provider. On 4/18, county receives the completed Doctor's Verification form stating that the individual needed NF LOC 1/1/2016. On 4/15/2018, NOA sent approving back to 1/1/2016 and triggers CSRA transfer period. CSRA transfer period ends on 7/31/2018. The CSRA transfer period begins as of 1/1/2018 and ends 7/31/2018, and includes the period of retroactive eligibility and ongoing eligibility.

Enclosure 8

Diagram 2
Completion of Request for HCBS



* County must make the referral. County attempts to confirm that the request for services is completed by verifying if:

- the individual is on the wait list
- the individual has applied for services
- the application for services is in progress, or
- the individual is in the program.

The request must be completed before the end of the continuous period of institutionalization.

** The continuous period of institutionalization ends when no inpatient care or HCBS request/participation exists for a full calendar month.

Enclosure 8

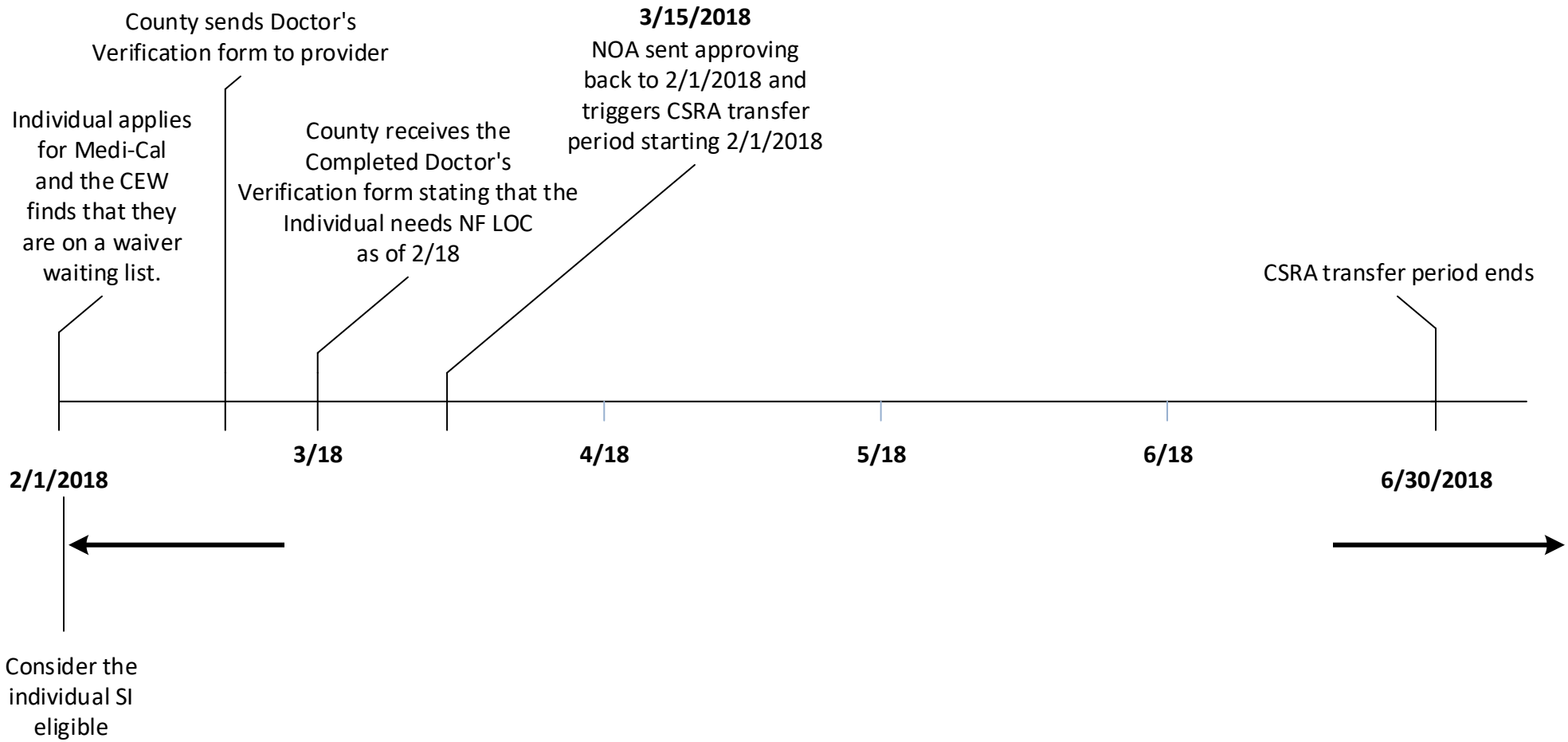
Diagram 2

This diagram demonstrates how the request for HCBS services is completed when the county applies the SI provisions retroactively to the applicable application date. On 5/1/2018, the individual applies for Medi-Cal and marks the box indicating interest in in-home care. On 5/20/2018, the county sends Doctor's Verification form to provider. On 5/30/2018, the county receives the completed Doctor's Verification form stating that the individual needs NF LOC. On 6/10/2018, the county determines eligibility and applies SI provisions back to 5/1/2018. The county must make the referral. The county attempts to confirm that the request for services is completed by verifying if: the individual is on the wait list, the individual has applied for services, the application for services is in progress, or the individual is in the program. The request must be completed before the end of the continuous period of institutionalization. The Continuous period starts on 5/1/18. The beneficiary must complete request for HCBS before the end of the continuous period. The continuous period of institutionalization ends when no inpatient care or HCBS request/participation exists for a full calendar month. If the beneficiary goes one full calendar month without services, then the county must assess for other eligibility. A 10-day NOA must be sent if HCBS request was not completed.

Enclosure 9

Diagram 3

Continuous Period of Institutionalization (HCBS)



* If the continuous period of institutionalization ends, then send a 10-day NOA per ACWDL 17-25 (continuous period of institutionalization ends when no inpatient care or HCBS request/participation exists for a full calendar month)

Enclosure 9

Diagram 3

This diagram demonstrates how the Continuous Period of Institutionalization (HCBS) operates when the county applies the SI provisions retroactively to the applicable application date. On 2/1/2018, individual applies for Medi-Cal and the CEW finds that they are on a waiver waiting list. The county sends Doctor's Verification form to provider. In 3/18, county receives the Completed Doctor's Verification form stating that individual needs NF LOC as of 2/18. On 3/15/2018, NOA sent approving back to 2/1/2018 and triggers CSRA transfer period starting 2/1/18. On 6/30/2018, CSRA transfer period ends. Consider the individual SI eligible as of 2/1/2018, and the Continuous Period of Institutionalization begins as of that date and continues forward. If the continuous period of institutionalization ends, then send a 10-day NOA per ACWDL 17-25 (continuous period of institutionalization ends when no inpatient care or HCBS request/participation exists for a full calendar month).