APPLE HEALTH (MEDICAID) MANUAL REVISION

Revision #	**038**
Chapter / Section	**Long term services and supports (LTSS)** **Determining eligibility for non-institutional coverage in an Alternate Living Facility (G03 or L52 group C and D)**
Issued Date	**1/1/2018**
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Summary of Revision
https://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/determining-eligibility-non-institutional

This section has been amending to update current terminology.

Changing Regional Support Network to Behavioral Health Organization.

Eliminating unnecessary links.

Apple Health (Medicaid) Manual revision via track changes:

https://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/determining-eligibility-non-institutional

Determining eligibility for non-institutional coverage in an Alternate Living Facility (G03 or L52 group C and D).

1/1/2018

Purpose: This program is used for SSI-related people receiving a long-term service and support (LTSS) such as Medicaid Personal Care (MPC)(G03) or Community First Choice (CFC) when countable income is over the CNIL, but under the Special Income Level (SIL) and state-contracted rate.

Starting 10/2015, CFC clients using these rules will be under medical coverage group L52.

This program is used for Behavioral Health Organizations (BHO) in alternate living facilities (ALF). (G03).

This program is used for SSI-related people paying privately in a state-contracted ALF under medically needy (CN) G95, G99.

Clarifying Information

This program is used for individuals who have countable income over the CNIL and living in a licensed, department contracted alternate living facility (ALF).

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Non institutional Medicaid in an ALF has the same program rules as SSI related Medicaid, but with a higher income standard.

The ACES medical coverage group (MCG) is G03 for MPC, and G95, G99 for private pay clients.

Effective 10/2015 CFC clients under group C and D will be in MCG L52.

For SSI-related individuals who are eligible to receive CN coverage because they are on SSI (S01) or are SSI related with income at or below the CNIL (S02), the higher standard used for non institutional Medicaid in an ALF is not needed because they already meet CN eligibility. MPC clients in an ALF will remain on the S01 or S02 program.

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The G03/G95/G99 medical coverage group is used for eligibility when an individual resides in an alternate living facility. The daily rate is what drives the eligibility. The difference in eligibility between the SSI related series (S02, S95, S99) and non-institutional in an ALF (G03, G95, G99) is the income standard. The standard is the daily rate x 31 days plus the ABD cash standard of $38.84.

For individuals receiving Home & Community Services (HCS), Developmental Disabilities Administration (DDA), or Behavioral Health Organization/Mental health (BHO) services with income at or below the Medicaid Special Income Level (SIL) use the state daily rate authorized for that individual.

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For private pay individuals in a state contracted/licensed facility, use the private daily rate

the individual is billed by the facility.

1. Categorically Needy (CN-P) G03

To be eligible for CN benefits, an individual must have non-excluded income at or below both the CN standard and the SIL and resources at or below the resource standard for SSI related individuals.
There are 2 tests for CN-P eligibility under the G03 program:

1.
    1. Is the individual's gross income under the Medicaid SIL? And;
    2. Is the individual's countable income under the state contracted daily rate x 31 days plus $38.84?

If the answer to both (a) and (b) are yes, the individual is income eligible for CN G03. If one or both are answered no, the case will trickle to a medically needy program.

2. Medically Needy (G95/G99)

The income standard used to determine eligibility for these benefits under the medically needy (MN) program is based on the private facility rate based on a thirty-one day month plus $38.84.
If the income exceeds the MN standard, the excess is used to determine the individual's spenddown liability. Refer to Spenddown for procedures.

3. What is a department contracted/licensed alternate living facility?

Department contracted facility means a licensed facility such as an adult family home or assisted living facility that is contracted with DSHS to provide services such as Medicaid Personal Care (MPC) or Developmental Disability Administration (DDA) or Home & Community Services (HCS) Waiver services. It also applies to facilities that are contracted with the Behavioral Health Organization (BHO) to provide services. The BHO provides Mental Health services. If the facility does not accept an individual with the BHO, DDA or HCS services it is not considered a department contracted facility. A facility can be licensed, but not contracted with DSHS or Mental Health. Eligibility for individual's living in a licensed but not contracted facility is done as if the individual is in their own home.
Facility rates can vary from one facility to another. The facility rate must be updated in ACES at each eligibility review and documented as to how the rate was verified.

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- The state rate is used for CN eligibility.
- The private rate is used for MN eligibility.
- The state and private rate could be the same, or the private rate could be lower than the state rate based on providing an individual with personal care services.

Some facilities that hold a contract with the department also have private-pay beds. Individuals not eligible for Medicaid or state payment for the cost of care in a department-contracted facility pay the private rate established by the facility. These individuals may still be eligible for non-institutional medical assistance using the rules for the G03 program.
To search for current Adult family Home or Boarding Homes contracted with DSHS.
The list on the Adult family home/Boarding Home indicates if the facility is not contracted for Medicaid or mental health.
Examples 1 through 5 how to determine if the facility is contracted for the purposes of G03.

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4. Room and Board, what does this mean?

Throughout the manual both terms, room and board and board and room are used to describe a living arrangement in which an individual purchases food, shelter, and household maintenance requirements from one vendor. There is also a term used by ALTSA called the room and board rate. This rate is based on the FBR minus the current PNA in an ALF used in the HCB Waiver program.
For individual's receiving medical through this program, the rate paid to the ALF is usually higher than the standard room and board rate used by ALTSA.
The rate individuals on G03/MPC pay the facility is their countable income after SSI related deductions and disregards minus $62.79 PNA. This rate for the purpose of the G03 program is called the individual's total responsibility. All other ALTSA individuals on MPC pay the standard room and board rate with the exception of G03 individuals.

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Do not use G03/G95/G99 in the following situations:

- CN SSI related Medicaid under S01 or S02.
  For SSI-related individuals who are eligible to receive CN coverage because they are on SSI (S01) or are SSI related with income at or below the CNIL (S02), the higher standard used for non-institutional Medicaid in an ALF is not needed because they already meet CN-P eligibility. Special income disregards for SSI-related programs such as disabled adult child (DAC) and COLA/Pickle are found in the clarifying section under WAC 182-512-0880. Individual's receiving services

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authorized by DDA or HCS pay the ALTSA room and board amount. SSI eligibility Medical.

- Healthcare for workers with disability (HWD)(S08)
  In most cases, individual's who are on Healthcare for Worker's with disabilities (HWD/S08) would be better off remaining on HWD if receiving services from HCS or DDA. HWD individuals on MPC would pay their HWD premium to financial service administration (FSA) and the ALTSA room and board amount to the ALF provider.

- Individuals receiving HCB Waiver services with DDA or HCS.

  - Individuals authorized for an HCB Waiver program through DDA (described in WAC 182-515-1510) or HCS (described in WAC 182-515-1505) may be living in an ALF. If the individual is authorized services through a HCB Waiver program, the L22 medical coverage group is used. There are exceptions to this if the client is eligible for HWD or D01 and receiving HCB Waiver services. The L22 Waiver medical coverage group is an institutional program using post eligibility rules to determine how much the client pays toward their cost of care. The amount the client pays along with the standard room and board amount is called participation. There are allowable deductions that can be used in post eligibility under an HCB Waiver program, but not allowed as a deduction in the SSI related rules used for the non-institutional SSI related in an ALF program. Some examples of these deductions allowed in the post eligibility process for the Waiver programs are guardianship fees, court ordered child support, health insurance premiums, incurred medical expenses and spousal allocation under the spousal impoverishment act.

- The Hospice program uses institutional rules under the L22 program for individual's who would benefit in using institutional rules.

For an individual electing Hospice and paying private to an ALF., Do use the G95 program as a priority if eligible. If not eligible under G95 rules, consider the L32 program for Hospice elections. Hospice description.

- Individuals residing in a non-contracted alternate living facility. (Private Facilities)
  Some facilities are totally private and do not contract with the department to provide services. Determine eligibility for individuals in non-contracted facilities as if they are in their own home. Do not use the amount the individual pays to the private non-contracted facility as a medical expense. Alternate living facilities such as private assisted living, private adult family homes are not medical institutions, therefore the amount the individual pays to the facility is not

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considered a medical expense. The standard used for residents of private non-contracted facilities is the MNIL standard.

- Individuals receiving medicaid under a MAGI program.

Examples of non-contracted and private facilities or home settings:

1. Residents of veteran's homes who received domiciliary or assisted living care are not eligible for Medicaid. The Department of Veterans Affairs is responsible for meeting the needs of the domiciliary or assisted living residents.

2. Private boarding home, continuing care retirement center (CCRC), private assisted living facilities, supported living, and state operated living alternative (SOLA). Determine eligibility as if they are in their own home. (S02/S95/S99).

- Examples 6 through 12 on choosing the correct medical coverage group based on the individual's circumstances.

Agency Responsibilities

Financial staff determines financial eligibility for financial and medical assistance programs.
For individuals receiving services from the BHO, HCS or DDA, the assigned case-manager/social service specialist indicates the state daily rate on the financial/social service communication form. If MPC or CFC is authorized, the assigned case-manager/social service specialist indicates the service, the date service was authorized along with the daily rate and type of facility. (For Internal staff)
HCS social service specialists use the DSHS 14-443 Financial/Social Service communication form. This form is automated through the barcode system.
DDA case managers use the DSHS 15-345 CSO/DDA Communication. This form is automated through the barcode system.
BHO case managers use the DSHS 13-348 BHO/CS0 communication form.

Worker Responsibilities

1. See WAC 182-513-1200 Long-term services and supports authorized under Washington Apple Health.

2. See SSI related Medical Income and SSI related Resources to determine income and resource eligibility.

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3. When an individual is placed in a facility on a HCS or DDA Waiver service, use Chapter 182-515 WAC to determine eligibility. Screen in a L22 for these programs.

4. When an individual is otherwise eligible for a SSI related CN program (S01 or S02) the S01/S02 program is a priority program. If an MPC S02 individual residing in a contracted ALF has an increase in income that causes the S02 to trickle to a S95, do a redetermination under the G03 program. Starting 10/2015 all CFC SSI-related clients using rules of this program will be under MCG L52.

5. HWD is a priority program for individuals on MPC or CFC when it is beneficial to the individual. Individuals on HWD pay the HWD premium plus the ALTSA room and board standard.

6. If the individual's non-excluded gross income is above the SIL and/or the department-contracted rate plus the PNA/CPI standard use the private facility rate plus the PNA/CPI standard. Cases that trickle to MN are not eligible for MPC or CFC. Consider eligibility for a HCB Waiver.

7. To determine the individual's spenddown liability for non-institutional medical assistance under the MN program, use the individual's non-excluded income in excess of the private rate plus the PNA to determine the individual's spenddown liability. Do not use the amount charged by the ALF to reduce the spenddown amount, however the individual may use other incurred medical expenses to meet spenddown. (ALFs are not medical institutions).

8. The agency will consider income and resources separately as of the first day of the month following the month of separation when spouses stop living together because of placement into a boarding home or adult family home when:

    1. Only one spouse enters the facility;

    2. Both spouses enter the same facility but have separate rooms; or

    3. Both spouses enter separate facilities.

9. The agency will consider income and resources jointly when spouses are placed in a boarding home or adult family home and share a room. See WAC 182-512-0960.

10. Indicate the type of services in ACES under HCB/MPC services under the institutional care tab in ACES 3G with the service start date indicated by the social worker and the agency authorizing the service (DDA or HCS).

11. Services authorized by DDA, HCS are tied to eligibility for CN Medicaid. If medicaid closes, the service authorized by the social service specialist/case

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manager must close too. Individuals must be eligible for a non-institutional CN medicaid program in order to receive MPC or CFC.

1. HCS social service specialists use the DSHS 14-443 Financial/Social Service communication form. This form is automated in barcode.

2. DDA case managers use the DSHS 15-345 CSO/DDA Communication form. This form is automated in barcode.

3. BHO case managers use the DSHS 13-348 BHO/CS0 communication form.

12. The assigned case manager/social service specialist indicates what services are authorized with the start date, the state daily rate, the current address and any other pertinent information needed to process the case such as if a payee or power of attorney is involved in the case. The assigned case manager/social service specialist determines the functional eligibility for the service; the financial worker is responsible to determine the financial eligibility for Medicaid. Changes need to be communicated back and forth between the financial worker and assigned case manager/social service specialist.

13. If G03 eligibility trickles to a G95 or G99 because the income is in excess of the SIL or the state daily rate and the individual is receiving MPC services, notify the agency approving the MPC service that the individual is no longer eligible to receive MPC because of excess income.

14. For people paying privately in a state-contracted ALF, contact the facility for the private rate.

15. To search for Adult Family Home or Boarding Homes contracted with DSHS: http://adsaweb/afhbh/