APPLE HEALTH (MEDICAID) MANUAL REVISION

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Chapter / Section	**182-513**
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Summary of Revision

Roads to Community Living | Washington State Health Care Authority

Roads to Community Living

Revised date

May 16, 2024

Purpose statement

To explain a long-term services and supports (LTSS) program called Roads to Community Living (RCL). RCL is for individuals who have been in a medical institution and may be able to live in the community if the additional services offered under RCL are provided. These services are provided either when the individual is in a medical institution or after they have been discharged.

WAC 182-513-1235 Roads to Community Living (RCL)

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Effective May 30, 2021

1. Roads to community living (RCL) is a demonstration project authorized under Section 6071 of the Deficit Reduction Act of 2005 (P.L. 109-171) and extended through the Patient Protection and Affordable Care Act (P.L. 111-148).
2. Program rules governing functional eligibility for RCL are described in WAC **388-106-0250** through **388-106-0265**. RCL services are authorized by the department.
3. A person must have a stay of at least sixty consecutive days in a qualified institutional setting such as a hospital, nursing home, or residential habilitation center, to be eligible for RCL. The sixty-day count excludes days paid solely by Medicare, must include at least one day of Medicaid paid inpatient services immediately prior to discharge, and the person must be eligible to receive any categorically needy (CN), medically needy (MN), or alternate benefit plan (ABP) Medicaid program on the day of discharge. In addition to meeting the sixty-day criteria, a person who is being discharged from a state psychiatric hospital must be under age twenty-two or over age sixty-four.
4. Once a person is discharged to home or to a residential setting under RCL, the person remains continuously eligible for medical coverage for three hundred sixty-five days unless the person:
    1. Returns to an institution for thirty days or longer;
    2. Is incarcerated in a public jail or prison;
    3. No longer wants RCL services;
    4. Moves out-of-state; or
    5. Dies.
5. Changes in income or resources during the continuous eligibility period do not affect eligibility for RCL services. Changes in income or deductions may affect the amount a person must pay toward the cost of care.
6. A person approved for RCL is not subject to transfer of asset provisions under WAC **182-513-1363** during the continuous eligibility period, but transfer penalties may apply if the person needs HCB waiver or institutional services once the continuous eligibility period has ended.
7. A person who is not otherwise eligible for a noninstitutional medical program must have eligibility determined using the same rules used to determine eligibility for HCB waivers. If HCB rules are used to establish eligibility, the person must pay participation toward the cost of RCL services. HCB waiver eligibility and cost of care calculations are under:
    1. WAC **182-515-1508** and **182-515-1509** for Home and Community Services (HCS); and
    2. WAC **182-515-1513** and **182-515-1514** for Development Disabilities Administration (DDA) services.
8. At the end of the continuous eligibility period, the agency or its designee redetermines a person's eligibility for other programs under WAC **182-504-0125**.

Clarifying Information.
WAC **182-513-1200** describes Long-term Services and Supports (LTSS).

What is RCL?

RCL is a demonstration project funded by the "Money Follows the Person" grant. The grant was received by Washington State from the federal Centers for Medicare and Medicaid Services (CMS). The purpose of the RCL demonstration project is to investigate what services and supports will successfully help people with complex, long-term care needs transition from institutional to community settings.

Who is eligible for the RCL project?

- People of any age with a stay of at least 60 consecutive days or longer in a qualified medical institutional setting; or
- Individuals in psychiatric hospitals with a stay of at least 60 consecutive days or longer who are under age 22 or over age 64. AND each of the following:
    - Receiving Medicaid-paid inpatient services immediately prior to discharge;
    - Interest in moving to a qualified community setting (home, apartment, licensed residential setting with 4 or less unrelated individuals at the time of placement);
    - On the day of discharge to begin the demonstration year, RCL participants must be functionally and financially eligible for, but are not required to receive, waiver or state plan services;
    - On the day of discharge, must be Medicaid eligible. If Medicaid is opened and it is subsequently discovered that the client was not eligible for Medicaid prior to the discharge from the institution, the Medicaid and RCL services may close. Examples of this are unreported resources or transfer of assets that would have caused a transfer penalty of ineligibility for long term care services, or it was determined the client is not a citizen.
- How long are participants eligible for RCL services?
    - Participants are entitled to continued medical coverage through the end of the month of the 365 days following their discharge date. This is called continuous medical eligibility.
    - The clock on demonstration period services stops if a participant needs to be re-institutionalized for greater than 30 days. The social worker/case manager will inform the PBS of the new 365day period if it has changed
    - Participants are not to be reassessed for financial Medicaid eligibility until the end of their 365-day demonstration period.
    - In order to receive Medicaid beyond the 365 period, a participant must be determined eligible to receive medical by the PBS.

More about Medicaid eligibility during the demonstration period

RCL participants remain eligible for Medicaid during the demonstration period regardless of any changes in financial circumstances, including:

- Acquisition of resources or income above program standards.
- Transfers of assets if this occurs after the discharge from the medical institution. If a transfer of asset is discovered that would have made a participant ineligible for Medicaid on the day of discharge, RCL and the Medicaid would be closed.

Financial eligibility will be reviewed at the end of the demonstration period. Clients must meet eligibility requirements for a medical/long-term care program at that time to continue to receive them after the 365-day period.

Worker Responsibilities

You will be notified by an HCS or DDA case manager that a client has been discharged from the medical facility to the RCL program.

HCS social workers use the **DSHS 14-443 Financial/Social Service Communication** via Barcode.

DDA case managers use the **DSHS 15-345 CSO/DDA Communication** via Barcode.

Change the Medicaid program

Most of the RCL clients will be receiving an institutional medical under L02. For most cases, you will change the ACES medical coverage group to RCL eligibility under L42 (L41 for an SSI recipient). The HCBS code for RCL is R.

RCL service lets you enter a future end date.This tells ACES to "push" the certification period to the end of the month of the RCL demonstration period. If the entered RCL Authorization end date is prior to the certification period end date, ACES will not "pull" the certification period back and the AU will eventually close for 281 - no waiver in the month of RCL ending.

The case manager/social worker will notify the PBS if there has been a change in the 365 days by submitting a 14-443 or 15-345 with a new ending date.

What if the client is on the Modified Adjusted Gross Income (MAGI) program in the medical facility?

MAGI clients, with the exception of N21 and N25, are eligible for RCL services. DSHS PBS are unable to issue RCL letters or make any changes on a MAGI case as these cases are maintained by the Health Benefit Exchange/Health Care Authority (HCA).

Note: The Expanded Apple Health program for non-citizens will be implemented on 7/01/2024 using MAGI N20. This state program does not include LTSS therefore those on the N20 program can’t receive RCL services.

What if the RCL client initially declines personal care services upon discharge?

The case manager/social worker will notify the PBS if the client has initially declined services upon discharge based on LTC chapter 29. The PBS will add freeform text to the ACES award letter: **If you choose to receive ongoing RCL services through your 365-day period, the amounts listed as total responsibility toward the cost of care will be your contribution to your provider. (Up to the cost of the actual services).**

EXAMPLE: RCL clients can start receiving services prior to the discharge from the medical institution. An example of this is a person who assists the client (called a Community Choice Guide) to find housing before they are discharged. Upon discharge, the client may choose not to have personal care services during the 365 days. The social worker/case manager will inform the PBS that the client is discharged under RCL and is declining ongoing services.

Provide continuous eligibility throughout the demonstration period

A change in financial circumstances that would ordinarily cause closure of the Medicaid assistance unit does not affect Medicaid eligibility for RCL clients. This only applies to Medicaid eligibility. The continuous eligibility guarantee does not apply to cash, food, state-funded medical or Medicare Savings programs.

If a change occurs during the demonstration period which may cause ineligibility at review, advise the client and the case manager that the change may affect eligibility after the demonstration period ends.

Are there any exceptions to continuous eligibility?

Yes. The only exceptions are:

- Citizenship
- Moving out of state
- incarceration for 30 days or more
- death
- It is determined the client was not eligible for Medicaid on the day of discharge. An example of this is an unreported resource, a transfer of asset that occurred within the 5-year look-back, individual determined not to be a citizen or have a valid Social Security number.

What if there is mail return?

If mail is returned, see if a forwarding address is provided.

- If one is provided, update the address. No further action is necessary.
- If one is not provided, the PBS will attempt to call the client via the phone number or inquire with the case manager as to the current address.
- If the PBS is still unable to determine where the client is, terminate the medical for loss of contact/whereabouts unknown. Advance notice is not necessary.

- If the client provides an updated Washington address at any time during the original 365-day period, the assistance unit is reinstated from the month of termination through the end of the original 365-day certification period. A new application is not necessary.

Determine the client's cost of care

Depending on the client's income amount, clients receiving RCL services may have to participate toward the cost of room and board and personal care in an alternate living facility (ALF) or for personal care costs in their own homes. Rules for determining the amount the client is responsible for are in WACs 182-515-1505 for HCS clients and 182-515-1510 for DDA clients.

What happens at the end of the 365-day period?

For non-SSI clients an eligibility review will be sent to the client and/or the client's representative for the annual review. After the 365-day period, a redetermination must be made. The client must meet income and resource eligibility under the HCS or DDA Waiver.

In addition to the financial eligibility, functional criteria for the HCS or DDA Waiver must be met. This must be confirmed by the current case manager.

Coordination with the agency case managing the service is important. If the client is no longer eligible under financial rules for another LTSS program or eligible for a non-institutional CN Medicaid program, the PBS will need to notify the case manager to close services on day 366 or as soon as possible once the review is completed. During the redetermination period, keep the Medicaid open even if it goes beyond 365 days unless we know the client is not eligible for any other Medicaid program.

If the client is eligible for a non-institutional categorically needy Medicaid program, Medicaid Personal Care (MPC) can be considered.

NOTE: During the 365day period after discharge from the medical institution, Medicaid is continued. A reconsideration is done for Medicaid eligibility beyond the 365-day period.

The agency authorizing services will communicate to the PBS by the 365th day.

- HCS social workers use the **DSHS 14-443 Financial/Social Service Communication** via Barcode.
- DDA case managers use the **DSHS 15-345 CSO/DDA Communication** via Barcode.

This communication should include what services, if any, will be authorized beyond the 365th day (either CFC or Waiver services).

For MPC, a client would need to be eligible for a non-institutional Medicaid program.

If services are not authorized by HCS or DDA, redetermine Medicaid eligibility using non-institutional Medicaid rules.

What happens if a client receiving RCL returns to a medical institution during the 365 period?

If the RCL client returns to a medical institution for a short stay (under 30 days), treat the case like any other short stay. Keep the case active on the current Medicaid program active in the community and issue the medical facility an award letter using the short stay screen.

If the RCL client returns to a medical institution and the placement is projected for over 30 days, the case will need to be changed back to the institutional program (L01 for SSI, L02, L95 track for SSI related, K track for children).

- Make sure the eligibility review is pulled back in ACES to reflect the month that is one year later than the last review was completed.
- If it has been over a year since a review has been completed, do the program change and pull the eligibility review to the last review while a redetermination is being made.
    - Send a new eligibility review for completion.
    - Set a Barcode tickler to check the status.
    - Keep the Medicaid case open while doing a redetermination of eligibility.
- Once a client is no longer in the RCL program, they must meet the income and resource eligibility for institutional medical.

It is possible that a client will be reenrolled in the RCL program again as part of discharge planning. If a client is placed back into the community under the RCL program, they are reenrolled in RCL for what remains of their 365 days. If the original 365-day end date has been changed, the social worker or case manager will notify the PBS.

Can clients who have previously completed their 365-day demonstration project reenroll in RCL? If so, how?

Yes, clients who are reinstitutionalized after their 365-day demonstration period is over may be reenrolled in RCL if the need is clearly stated and the new plan of care has been reviewed. The purpose of reenrollment planning is to ensure that a thorough look is taken at why the original plan did not result in long term successful community placement, and to outline how the new plan addresses the identified gaps.

If the client has been subsequently reinstitutionalized for at least 60 consecutive qualified days, he/she/they may be reenrolled in RCL for another 365-day demonstration period using the following process. All processes outlined above apply for the 2nd enrollment.

How can the PBS tell if it is an RCL case?

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- The client will be active on an L41 if SSI or an L42 if SSI-related.
- The PBS will indicate in the narrative and remark behind the institutional screen the client was approved for Roads to Community Living/RCL.