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

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Director

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TO: ALL COUNTY WELFARE DIRECTORS Letter No.: 17-34
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS

SUBJECT: Counties' Responsibilities for the Monthly Long-Term Care Aid Code Report
(Reference: Medi-Cal Eligibility Procedures Manual Article 8B; All County Welfare Director's Letters: 90-01, 02-59, 03-24, 07-24, and 15-21; and Medi-Cal Eligibility Information Letters: I 14-06 and I 14-11)

Introduction

This All County Welfare Director's Letter (ACWDL) serves as a follow-up to ACWDL 15-21 regarding monthly Long-Term Care (LTC) aid code reports. This report contains the names of beneficiaries with a Treatment Authorization Request (TAR) for recurring nursing facility care, but are not in a LTC aid code in the Medi-Cal Eligibility Data System (MEDS).

As of the date of publication of this ACWDL, counties are required, on a quarterly basis, to follow up with the Department of Health Care Services' (DHCS) Medi-Cal Eligibility Division (MCED) via the procedure outlined below. It is important that counties investigate and take action for each individual on this report to ensure program accuracy, the beneficiary receives the most comprehensive coverage, and the State receives all funds to which it is entitled.

Aid Codes and LTC Services

Beneficiaries are entitled to receive LTC services provided under different aid codes. Modified Adjusted Gross Income (MAGI) Medi-Cal beneficiaries are entitled to LTC under any of the MAGI aid codes without the need to change to a Non-MAGI LTC aid code. Supplemental Security Income/State Supplementary Payment (SSI/SSP) beneficiaries may also receive LTC services under the SSI/SSP aid codes. For all other Medi-Cal groups, counties must evaluate and transition beneficiaries to specific LTC aid

codes in order to receive LTC services, if the LTC stay is expected to be longer than two months. A beneficiary is in LTC status once they are expected to remain in LTC for at least one full calendar month past the month of admission.

The full-scope Non-MAGI LTC aid codes include:

- 13 (Aged, Medically Needy);
- 23 (Blind, Medically Needy),
- 63 (Disabled, Medically Needy).
- 53 (Medically Indigent, non-Federal Financial Participation).
- 55 (Undocumented Aliens in LTC, not PRUCOL.)

Aid code 53 is limited to services necessary in LTC, and aid code 55 is a restricted scope LTC aide code that covers undocumented aliens in LTC not Permanently Residing in the United States Under Color of Law. Recipients remain in aid code 55 even if they leave LTC.

Background and Definitions

ACWDL 90-01 contains the draft regulations and definitions applicable to individuals in LTC. Section 50056 defines LTC status, as it applies to single individuals. For spousal impoverishment cases, section 50031.5 defines "community spouse," section 50046.5 contains the criteria for an "institutionalized spouse," and section 50033.5 defines the term "continuous period of institutionalization."

The LTC aid code report contains the "TAR Request dates/TAR approved dates" to assist the county in determining if the beneficiary is, in fact, in LTC. If these dates reflect a 30-day or longer period, this is an indication that the beneficiary is receiving LTC services, and their care meets the definition of LTC status. The report also contains the "TAR Admit Date", which is the date the beneficiary was first admitted. If the TAR request date and TAR admit date are different, it could mean the beneficiary was admitted at an earlier date, and required another TAR to cover a longer period, or that Medicare initially covered the beneficiary's stay.

Objective

In order to ensure that beneficiaries are in the appropriate aid category and aid codes, the counties shall:

1. Review the monthly LTC aid code report.

2. Research beneficiary cases.
3. Take appropriate action, if necessary.
4. Follow-up with DHCS MCED.

1. Review the monthly LTC Aid Code Report

Each month, DHCS MCED securely provides each county with a list of beneficiaries receiving LTC services, but are not in a LTC, MAGI or SSI/SSP aid code in MEDS. DHCS typically transmits the LTC aid code report to the county by mid-month. Upon receipt of the report, the county is responsible for reviewing its contents.

2. Research Beneficiary Cases

Subsequent to reviewing the report, the county must complete case research to determine the reason why the beneficiaries contained within the report are receiving LTC services, but are not in a LTC aid code in MEDS. The reasons beneficiaries appear on the LTC aid code reports are varied. It is up to the counties to review each beneficiary's particular circumstances and history in MEDS, as well as the information contained in the LTC aid code report, such as the TAR Approved Dates and TAR admit date, and analyze the information to determine the appropriate course of action.

It is also important for the county to review the share of cost (SOC) calculations. For example, spousal impoverishment rules could result in no SOC in cases where one would expect the beneficiary to have a SOC. Similarly, a single individual who was receiving Medi-Cal with a SOC will likely have a higher SOC if he or she transfers to LTC status.

3. Take appropriate action, if necessary

There will be cases that require no further action from the county, such as when the beneficiary has LTC status for less than 30 days. However, many cases may require the county to redetermine eligibility pursuant to the hierarchy in ACWDL 17-03, particularly those beneficiaries who are in certain aid categories including Aged, Blind, or Disabled Federal Poverty Level; Pickle; Medically Needy with a SOC; and *Craig v. Bonta* cases.

In conducting the redetermination, if the beneficiary is found to be eligible to the LTC program but failed to report their LTC status timely, and the beneficiary is competent and does not have an authorized representative, the county can complete a LTC budget calculation and process an overpayment back to the month the beneficiary would have had a SOC or increased SOC with 10-day notice. Counties should first check the

California Healthcare Eligibility and Enrollment Retention System for any other pending applications. Counties are to ensure the correct aid code is reported in MEDS for future months only, and follow rules with respect to providing 10-day notice when completing certain actions such as increasing SOC.

The following examples do not represent every scenario the county may encounter, but are representative of the types that may frequently arise in the monthly report:

Beneficiary was in LTC for a partial month only

For a single person, LTC status occurs if the length of stay is longer than 30 days, whereas, an institutionalized spouse achieves LTC status immediately. If the TAR approved dates are shorter than 30 days, the beneficiary is not in LTC status, and therefore no further action is needed.

Beneficiary is deceased.

If the beneficiary is deceased, ensure that MEDS has the date of death, and reflects eligibility for the month of death.

Beneficiary receiving Medi-Cal with a SOC and admitted to a nursing facility.

If a beneficiary is already receiving Medi-Cal with a SOC and not in LTC status, when he or she is admitted to a nursing facility the county needs to conduct a redetermination of the beneficiary's case. Similarly, once in LTC status, a beneficiary who had no SOC while in the community (under a non-MAGI aid code) may now have a SOC due to the lower maintenance need under LTC budgeting (Title 22 California Code of Regulations Section 50653). In this example, the county must reevaluate the beneficiary's eligibility by first conducting a MAGI screening for LTC individuals, followed by a non-MAGI determination if not eligible under MAGI.

Beneficiary receives services under one of the MAGI aid codes.

DHCS changed the LTC aid code report parameters to exclude individuals in MAGI aid codes. Beneficiaries in MAGI aid codes, including those enrolled in managed care plans, do not need to transition to LTC Aid Codes to receive LTC services and supports (see Medi-Cal Eligibility Division Information Letters I 14-06 and I 14-11).

The beneficiary's address information is outdated.

Some beneficiaries might appear in the LTC aid code report because their address information is not up-to-date. For example, if the beneficiary moved out of a LTC facility and failed to notify the county, he or she will still show in the system as residing in a LTC facility. If the county determines that this is the case, the county should update the system to reflect the beneficiary's changed circumstances (i.e. new address), assuming the beneficiary is already in the correct aid code. If there are additional changed circumstances, such as a change of income, for Non-MAGI beneficiaries the county should conduct a MAGI determination, followed by non-MAGI and Advanced Premium Tax Credit determination, or if in a MAGI aid code, complete a non-MAGI determination.

Beneficiary is in a LTC Aid Code

If the beneficiary is already in a LTC Aid code, with or without a SOC, and the county has no information indicating the beneficiary is no longer in LTC, then no further action is needed as long as their residence address is correct and their SOC is correct.

Craig v. Bonta Cases

Welfare and Institutions Code, Section 14005.37 requires that whenever the county receives information about changes in a beneficiary's circumstances that may affect eligibility for Medi-Cal benefits, the county shall promptly redetermine eligibility. In the *Craig v. Bonta* case, the court held that Section 14005.37 applies to SSI/SSP Medi-Cal beneficiaries discontinued from SSI/SSP for exceeding SSI/SSP income and property requirements. These beneficiaries are in aid codes 1E, 2E, and 6E. If the beneficiary listed on the LTC aid code report was recently discontinued from SSI/SSP because their income exceeds the LTC payment rate, the county should redetermine eligibility because the beneficiary may now be eligible with a SOC. The county shall evaluate the *Craig v. Bonta* beneficiary pursuant to the hierarchy in ACWDL 17-03 within the 45-day timeframe.

4. Follow-up with DHCS MCED

Counties shall follow-up with DHCS MCED on a quarterly basis by listing the status for each beneficiary's case on the spreadsheet (Excel file) provided to the county in the form of the monthly LTC aid code report. Counties may provide their feedback on each monthly report, or combine the monthly reports into one quarterly report, then securely

transmit the file(s) to DHCS MCED via electronic mail (email) to LTCaidcodereport@DHCS.ca.gov. DHCS will review the counties' submissions, and will randomly sample individual beneficiary cases to confirm that the reported actions were completed.

If you have any questions or if we can provide further information, please contact Brooke Hennessy at (916) 327-0415 or by email at Brooke.Hennessy@dhcs.ca.gov or Eric Sweeney at (916) 327-0412 Eric.Sweeney@dhcs.ca.gov.

Original Signed By

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