STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
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TO: All County Welfare Directors

Letter No. 80-41

LONG-TERM CARE (LTC) ADMISSION AND DISCHARGE PROCEDURES

Attached are procedures describing use of the MC 171, Medi-Cal Long-Term Care Facility Admission and Discharge Notification Form (Revised) and MC 171A, Long-Term Care Facility Information Sheet for Public Assistance or Medi-Cal Recipients (new) which were developed as a means to notify the Social Security Admistration and county welfare departments on a more timely basis of SSI/SSP and Medi-Cal recipients who enter or leave an LTC facility.

County Welfare Department Responsibilities

Upon receipt of an MC 171 for an MN or MI recipient, the county is responsible for taking appropriate redetermination action.

The MC 171 for an SSI/SSP recipient is sent to the county only to provide an indication of potential medically needy applications. No action is required by the county until such time as an application is made.

It is anticipated that the MC 171 and MC 171A procedures will be implemented shortly after November 1, 1980 but no later than December 1, 1980.

The enclosed procedures and a copy of the MC 171 and MC 171A will be incorporated in the Medi-Cal Eligibility Manual, Procedures Section, within the near future.

If you have any questions you may contact your Medi-Cal Eligibility Field Representative.

Sincerely,

Original signed by

Barbara V. Carr, Acting Chief
Medi-Cal Eligibility Branch

Attachments

cc: Medi-Cal Liaisons
Medi-Cal Field Representatives
Expiration Date: May 31, 1981

LONG-TERM CARE (LTC) ADMISSION AND DISCHARGE PROCEDURES

I. Background Information

The Medi-Cal Long-Term Care Facility Admission and Discharge Notification Form, MC 171 (revised in May 1980), was developed as a means to notify the Social Security Administration (SSA) and the counties on a more timely basis of Supplemental Security Income/State Supplementary Payment (SSI/SSP) and Medi-Cal recipients who enter or leave an LTC facility. The objective is to reduce the number and dollar amount of overpayments that may occur because of delays in reporting the recipient's change in status.

The MC 171 is intended for statewide use, and is to be used when SSI/SSP or medically needy/medically indigent (MN/MI) recipients enter or leave LTC. The form is to be completed by the recipient, representative payee, or other person acting on behalf of the recipient, with assistance of the facility staff as needed. The LTC facilities are to send the MC 171 to the appropriate SSA district office and to the appropriate county welfare department via the Department's Medi-Cal field office.

The MC 171 form has replaced form SFRO-D00-106 (Social Security), previously used by LTC facilities to advise SSA of those SSI/SSP recipients entering or leaving LTC. Counties shall continue to use the form SSA 8221 CA to notify SSA of general status changes concerning SSI/SSP recipients.

A second form, the Long-Term Care Facility Information for Public Assistance or Medi-Cal Recipients (MC 171A) was developed for use by the LTC facilities to advise SSI/SSP and Medi-Cal only recipients of the need to complete the MC 171 and to inform SSA and county departments of their change in status. Since the MC 171A is for information only, no action is required by the counties as a result of this form.

These forms may be ordered from Computer Sciences Corporation by the facilities. Copies of both forms are included in the forms section of the Eligibility Manual.

II. Admissions Procedures

A. General Instructions

As soon as an SSI/SSP or MN/MI recipient is admitted to an LTC facility, the MC 171 and MC 171A is given to the recipient by the facility. The MC 171 form will be completed by the recipient or a representative payee and the facility; it should be signed by the recipient if possible. The original of the MC 171 is sent to the local Social Security office, a copy is sent to the Medi-Cal field

office, and the facility should retain a copy for their records. The Medi-Cal field office will forward the MC 171 to the appropriate county welfare department based on the location of the particular facility.

Signing of the form by the recipient is not mandatory, but will expedite the processing of the case by the Social Security office. The recipient's signature on the form verifies that there is a change of circumstance (and possibly status), and allows the local Social Security office to take more immediate action. If a signature cannot be obtained, the reason will be documented by the facility representative in the designated space (i.e., comatose beneficiary). Documentation is important. If no reason is given, an SSA representative must set up an appointment with the recipient to document the circumstances prior to taking redetermination action.

B. SSA Responsibilities

1. SSI/SSP Recipients

Upon receipt of the MC 171, the SSA grant reduction and termination process is initiated since a properly completed MC 171 (signed by the recipient) will serve as a first-party report.

A Notice of Proposed Action (SSA 8155A) is prepared and sent to the recipient immediately upon receipt of a properly completed MC 171. After the Notice of Proposed Action is issued, the district office may ask the recipient to waive his or her right to a timely notice so that action can be taken immediately. If the waiver is not obtained, the district office will take the appropriate action effective no later than 35 days (30 days plus 5 days mailing time) after issuance of the Notice of Proposed Action, unless the recipient asks for a reconsideration (i.e., fair hearing).

SSA will determine whether or not SSI/SSP payments will be terminated and the effective date of the termination. If terminated, an SSA "Notice of Change" is sent to the recipient. Until such notice is received, the recipient will continue to receive a monthly SSI/SSP gold check and a monthly SSI/SSP based Medi-Cal card, which is to be used by the facility for billing Medi-Cal. All questions concerning a person's SSI/SSP eligibility should be referred to the local SSA offices.

2. MN/MI Recipients

MC 171s for MN/MI recipients are sent to the local Social Security office for informational purposes only; no action will be taken by SSA.

EDI-CAL LONG-TERM CARE FACILITY ADMISSION AND DISCHARGE NOTIFICATION FORM
(Instructions and Distribution on Reverse Side of Form)

I. COMPLETE THIS PORTION FOR ALL ACTIONS

's Name Last First MI	Name of Facility
:ial Security Number	Address (Number and Street)
ıte: Level of care is SNF/ICF unless checked here as board and care ☐	City State Zip Code

II. COMPLETE THIS PORTION ONLY FOR ADMISSIONS

di-Cal ID Number (Taken from the Medi-Cal Card)	Date of Admission (Month/Day/Year)

A. Do you have Medicare Part A, Hosp. Coverage?
☐ Yes ☐ No

B. Expected length of stay
☐ At least one full month after the month of admission
☐ Less than one full month after the month of admission

C. Medi-Cal is expected to pay over 50% of facility cost of care.
☐ Yes, beginning with Month of ____________ 19 ______.
☐ No, other insurance, private pay, etc.

D. Current income (check all applicable boxes)
☐ Supplemental Security Gold Checks
☐ Social Security Green Checks
☐ Other Income (i.e., railroad, military retirement, etc)
☐ None

E. Admission from . . .
☐ Home ☐ Board and Care
☐ Household of Another
☐ Acute Hospital – Home, B&C, Other Household immediately prior to acute
☐ Acute Hospital – SNF/ICF immediately prior to acute
☐ Acute Hospital extended stay – over 30 days.
☐ Another SNF/ICF

F. If known, enter your address prior to facility admission. If admitted from an acute hospital, enter your address prior to the acute hospital admission. (Do not give the acute hospital's address)

Address (Number and Street)
City State Zip Code

G. Signature of Recipient or Representative Payee or Family Member/Other

ıature of Recipient	Signature of Rep. Payee	Phone No.
ecipient's Signature Cannot be Obtained, Please Indicate Reason in This Space		
ıature of Family Member/Other (Indicate your Relationship to the Recipient)		Phone No.

III. COMPLETE THIS PORTION ONLY FOR DISCHARGES

A. Reason for discharge

☐ Discharged to Acute Hospital

☐ Discharged to Another SNF/ICF

☐ Discharged to Residence/Home of Another

☐ Discharged to Board & Care

☐ Discharged to Other

☐ Discharge due to death

B. Date of Discharge (Month/Day/Year)

C. Medi-Cal ID Number (Taken from the Medi-Cal Card)

D. Complete forwarding address for discharges other than death.

Name of Facility (If not Discharged Home)
Address (Number and Street)
City State Zip Code

ility Representative Signature	Date

I. General Instructions:

This form is to be used for each admission and discharge. Please do not use this form for Medi-Cal reauthorizations.

II. Admission Instructions

A. Preparation

Prepare an original and two copies of this form for each SSI/SSP and/or Medi-Cal admission.

B. Distribution

Original: Send to your local Social Security Office.

Copy 1: Attach to the Treatment Authorization Request (TAR) form and send to the Department of Health Services, Medi-Cal Field Office for your area. It will be forwarded by the Medi-Cal Field Office to the County Welfare Department.

Copy 2: Retain for your file.

III. Discharge Instructions

A. Preparation

Prepare an original and two copies of this form for each SSI/SSP and/or Medi-Cal discharge. Instead of completing a new form, use Copy 2 of the form retained in your file as part of the admissions process. Complete Part III of the form (which becomes the original for the discharge process), and make two copies.

B. Distribution

Original: Send to the Medi-Cal Field Office

Copy 1: Send with the original to the Medi-Cal Field Office. The Medi-Cal Field Office will forward this copy to the county welfare department.

Copy 2: Retain for your file.

IV. Explanation of over 50% of cost of care mentioned in Item II-C of this form.

Cost of care is the daily charge per patient excluding any additional services rendered to the patient which are billed separately by other providers (i.e., ambulance, physician, pharmacy, etc.).

For example, if the daily rate is $30 per day, the monthly charge for a 30-day month would be $900. If a patient enters the facility during the month of January, and is expected to stay at least one full calendar month after the month of admission (through February), a "YES" response would be indicated for Item II-C if Medi-Cal is expected to pay over $450 of the $900 charge for February.

LONG-TERM CARE FACILITY INFORMATION SHEET FOR PUBLIC ASSISTANCE OR MEDI-CAL RECIPIENTS

The long-term care (LTC) facility to which you are being admitted must comply with various federal and state regulations in order for its services to be paid for by the Medi-Cal program. Please cooperate with the LTC facility in completing any federal and state forms that must be prepared. The information you provide on these forms will assist in ensuring that you receive all of the benefits to which you are entitled without any undue delays. The Medi-Cal Long-Term Care Facility Admission and Discharge Notification Form (MC 171) which you have just been asked to complete is such a form.

California Administrative Code, Title 22, Section 50185, says that as a Medi-Cal recipient you must report any changes in circumstances that might affect your eligibility for Medi-Cal no later than 10 calendar days following the date of the change. To assist you in reporting this type of change in your circumstances, the LTC facility will send the MC 171 to the appropriate Social Security Office and the county welfare department on your behalf. You are still responsible for ensuring that the proper action is taken in regard to your eligibility for Medi-Cal benefits, and therefore, if you do not hear from either SSA or the county within 45 days, please contact them immediately.

Depending on your individual situation, you may have to pay or obligate to pay a portion of your medical costs before Medi-Cal can pay for the rest of your care. This obligation is referred to as the recipient's share of cost. A worker from the county welfare department will determine whether you have a share of cost and the amount of any obligation now that you have entered an LTC facility. Persons in LTC facilities who have a share of cost pay or obligate the share of cost directly to the facility.

You have the right to a fair hearing if you are dissatisfied with any action taken by the county welfare department or the State Department of Health Services. If you wish to ask for a fair hearing, you must do so within 90 days after the date the notice of action was sent by the county or the date of the action with which you are dissatisfied.

To request a fair hearing, write to the Office of Chief Referee, Department of Social Services, 744 P Street, Sacramento, CA 95814. You may also request a fair hearing by calling Toll Free: 800-952-5253.

If you want a family member to act on your behalf or you have any questions or need other services, please contact your county welfare department for assistance.