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January 23, 1996

MEDI-CAL ELIGIBILITY PROCEDURES MANUAL LETTER NO.: 156

TO: All Holders of the Medi-Cal Eligibility Procedures Manual

The purpose of this letter is to transmit new procedures for Title 22, Article 3 County of Responsibility. These procedures supersede current Article 3, County of Responsibility procedures, All County Welfare Directors Letter (ACWDL) No. 91-23 **and** ACWDL No. 86-33, Question 6.

The procedures issued with this letter incorporate:

1) federal and state regulations;
2) ACWDL references;
3) county welfare department (CWD) input; and
4) questions raised by applicant/beneficiary representatives.

Examples included in these procedures are not intended to address every situation. Rather, they are intended to function as guidelines for CWD staff when accepting/processing an application or retaining a continued eligibility case. Specific changes to the procedures deal with courtesy applications and applications for applicants who are unable to act on their own behalf.

Upon receipt of these procedures, CWD staff shall evaluate/review each case file on a case-by-case basis at intake and redetermination. CWD staff shall **NOT** proceed with mass intercounty transfers with their Long-Term Care status cases.

These procedures affirm the Department's goal to provide public access to services and to issue benefits promptly. Medi-Cal Eligibility Branch would like to thank CWD staff for their input on these procedures. CWD staff have suggested that adding a quick reference chart to these procedures for eligibility workers would be useful as a desk tool. My staff is working on the reference guide and it will be issued at a future date under a separate procedures manual letter.

Procedure Revision	Description
Article 3	Revised procedures for County of Responsibility, including Intercounty Transfers

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If you have any questions, please call Alice Mak of my staff at (916) 654-0573.

Sincerely,

Original signed by
Barbara Rahm for

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

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3A–GLOSSARY
COUNTY OF RESPONSIBILITY

The following definitions are used to clarify the examples given in the following Procedures for Article 3, County of Responsibility to determine which county is responsible for accepting applications, completing eligibility determinations, and issuing benefits.

Authorized Representative: Person specifically designated in writing (MC 306) by the applicant/beneficiary to accompany, assist, and represent the applicant/beneficiary in the Medi-Cal application/redetermination process. **An authorized representative cannot act on behalf of an incompetent individual.** [Medi-Cal Eligibility Branch (MEB) Procedures Manual - Article 4N and Title 42, Code of Federal Regulations (CFR) 435.908]

Competent: Able to act on one's own behalf in business and personal matters. [Title 22, California Code of Regulations (CCR), Section 50032]

Conservator: A person appointed by the court to act as the guardian, custodian, or protector of another. [MEB Procedures Manual - Article 4N]

First County: The county currently issuing or certifying benefits.

Home: Real or personal property, fixed or mobile, located on land or water, in which a person or family lives. [Title 22, CCR, Section 50044]

Institutionalized: Individual living in an establishment or facility that provides food, shelter, treatment or services to four or more persons unrelated to the proprietor. [Title 22, CCR, Sections 50047 - 50052.5]

Long-Term Care (LTC) Status: Inpatient medical care which lasts for more than the month of admission and is expected to last for at least one full calendar month after the month of admission. [ACWDL 90-01 Draft regulations, Section 50056]

Medi-Cal Family Budget Unit (MFBU): Persons who will be included in the Medi-Cal eligibility and share of cost determination. [Title 22, CCR, Section 50060]

Placement: When an individual is put into a board and care home, foster care home, treatment center, acute care hospital, skilled nursing facility, or a State hospital by a public agency/private person where food, shelter, treatment or services are provided. [Title 22, CCR, Sections 50025.3, 50047 - 50053]

NOTE: **Valid Aid Codes for children placed by a county agency in foster or adoptive care are 03, 04, 4C, 4K, 5K, 40, 42, and 45.**

Aid Codes 43 and 46 referenced in ACWDL 90-01, draft regulations, Section 50125(a)(1)(B) are no longer valid. Aid Codes 44 and 47 are Income Disregard Program Codes for pregnant women and infants up to one year of age.

Principal Residence: A home or a former home. A principal residence is **NOT** used in determining the County of Responsibility for an applicant/beneficiary. Principal residence is used to exempt a property from the property reserve. [Title 22, CCR, Sections 50401 - 50425 and MEB Procedures Manual - Article 9]

Public Agency: An administrative division of a local, state, or federal governmental agency, or an organization that has a contract to act on behalf of the local, state or federal government. [Title 22, CCR, Section 50077]

Public Guardian/Conservator: A county agency acting as a public entity appointed to act on behalf of persons who have lost their ability, either mentally or physically, to handle their own affairs. [MEB Procedures Manual - Article 4N]

Representative: A person acting on behalf of another who is incapable of handling his/her own personal or business affairs. **The representative MUST have specific and personal knowledge of the incompetent person's circumstances. A representative is different from an Authorized Representative.** The representative may be a friend, relative, or someone that has known the applicant/beneficiary and will act responsibly on the applicant/beneficiary's behalf. [MEB Procedures Manual - Article 4N]

Residence: Place in which a person or family lives or is physically present, if the person or family has no present intention of leaving. [Title 22, CCR, Section 50087]

Second County: The county to which the beneficiary moves to make his/her home.

Temporary Absence: Person maintains personal articles at home. The person leaves and returns to the home in the same month or the following month. [ACWDL 90-01, draft regulations, Section 50071]

Third County: Any subsequent county to which the beneficiary moves to make his/her home before the expiration of the transfer period.

Transfer Period: The period during which the first county remains responsible for issuance of benefits. The period expires at the end of the month after the 30-day notification to the second or third county.

3B–INTRODUCTION
COUNTY OF RESPONSIBILITY

Article 3 procedures are administrative guidelines for counties to process Medi-Cal applications and to ensure that benefits and services remain accessible to applicants, beneficiaries, and representatives acting on behalf of the applicants/beneficiaries. The objective of these procedures is to provide counties with information to administer the Medi-Cal program in a coordinated and efficient manner within the state and grant benefits promptly. The Department recognizes that there will be situations other than those identified in the examples contained in these procedures. **In the best interest of the Medi-Cal applicant/beneficiary, the Department expects counties to resolve County of Responsibility and Intercounty Transfer issues locally. The overriding principle must be that benefits are issued without delay.**

In resolving County of Responsibility issues, County Welfare Department (CWD) staff shall consider criteria such as:

1) the age of the applicant/beneficiary and his/her representative,
2) the physical and mental condition of the applicant/beneficiary,
3) the travel distance for the applicant/beneficiary and his/her representative, and
4) the possible delay in the processing of the application and eligibility determination that will create an undue hardship for the applicant/beneficiary and/or his/her representative.

The latest revision of Title 22, Article 3, County of Responsibility procedures is a result of concerns raised by the increasing number of applicants/beneficiaries entering Long-Term Care (LTC) facilities. It is reasonable for CWD staff to use the county of residence in determining the county responsible for accepting applications, determining eligibility, and issuing benefits. Staff who are working with the applicants, and/or their representatives shall be flexible in determining which state regulation or example takes precedence when an application is filed on behalf of an incompetent resident living in another county within the state. CWD staff shall accept the application, review the Statement of Facts, assist the applicant representative in gathering information, coordinate with other county agencies, if necessary, in the eligibility determination process, and issue benefits.

3C--COUNTY OF RESPONSIBILITY

1. LEGISLATIVE BACKGROUND

Title 22, California Code of Regulations (CCR), Article 3 regulations are policy guidelines set by the State to administer the federal Medicaid Program. Federal law mandates that the state administer the program simply and consistently. The Department of Health Services (DHS) functions as an agent for the federal government, adopts state statutory requirements to ensure that Medicaid eligibility is determined in the best interest of the applicants/beneficiaries, and monitors Medicaid programs and health care services locally. The intent of the federal and state legislation is:

1) to provide services and operate programs in an uniform manner throughout the State,
2) to assist the applicant, or person acting on the applicant's behalf, in the application and eligibility determination process, and
3) to issue Medicaid benefits to all eligible persons timely and accurately.

According to regulations in Title 42, Code of Federal Regulations (CFR) 435.403, an individual meets the residency requirement when he/she is physically present in the state with the intention to remain permanently or for an indefinite period. Federal regulations require that the state where the individual is physically residing be the state responsible for issuing Medicaid benefits.

42 CFR 435.906 states that the agency (Department) must afford an individual wishing to apply for Medicaid the opportunity to do so without delay. Welfare and Institutions (W & I) Code Section 14005 states that health care benefits and services shall be provided to any eligible person who is a resident of the state. Federal and state law require that when a person establishes residency in the state, he/she is eligible to apply for Medicaid in any county within the state.

2. COURTESY APPLICATION

The Department's policy on courtesy applications is that the county in which an applicant or his/her representative applies for benefits is the county responsible for making the initial eligibility determination even if it is not the applicant's county of residence. The county in which the individual or his/her representative applies must accept and process the application. If all of the information required for making the eligibility determination is available, the county shall issue benefits promptly before the case information, including verifications, are transferred to the beneficiary's residence county, the County of Responsibility. [Reference: Title 22, CCR, Section 50135 (c)]

If information is not available to the county that accepts an out-of-county application to process or complete the eligibility determination, the county shall forward the application and all information collected within 15 days from the date of application to the County of Responsibility for follow-up and completion of the initial eligibility determination.

Example 1: An individual lives in County A and becomes ill in County B. The individual is immediately admitted to a hospital in County B. County B has an outstationed Eligibility Worker (EW) at the hospital who receives a Medi-Cal referral from the hospital staff. The individual, with the EW's assistance, can complete the Application (SAWS 1), Statement of Facts (MC 210), participate in the face-to-face interview, and provide County B with sufficient information to determine initial eligibility. County B

shall grant the individual's Medi-Cal benefits before transferring the continued eligibility case responsibility to County A, the beneficiary's home county.

Example 2: An applicant representative applies in County A on behalf of an individual who resides in County B. The individual is hospitalized and unable to complete and participate in the application/eligibility determination process in County B. County A shall accept the Medi-Cal application from the applicant representative. If the applicant representative has knowledge of the applicant's income/resources and can provide County A with information to process the Medi-Cal application, County A shall determine initial eligibility and grant Medi-Cal benefits to the individual. County A would then transfer the continued eligibility case responsibility to County B.

3. LONG-TERM CARE - Incompetent/Incapacitated Individuals

The following examples shall be used in determining the County of Responsibility when a community spouse, family member or representative is applying for an incompetent/incapacitated individual residing in an LTC facility.

If the applicant's/beneficiary's community spouse, family member, or representative lives in another county within the state of California, county staff are **expected** to work with the applicant/beneficiary and his/her representative to expedite the application/redetermination process. Assistance for the applicant/beneficiary and/or his/her representative **shall** include but not be limited to: 1) reviewing the Statement of Facts (MC 210), 2) gathering information, 3) conducting off-site interviews at the LTC facility if the applicant is incapacitated but is able to participate in the face-to-face interview, and 4) issuing benefits.

When CWD staff is working with an applicant/beneficiary representative or an authorized representative(AR) for a person in an LTC facility, staff MAY review/reference the following procedures and All County Welfare Directors Letters (ACWDL):

* MEB Procedures Manual Article 4N: Timely Reporting by Public Guardian/Conservators or Beneficiary Representatives;
* ACWDL 95-30: Questions and Answers regarding the MC 306 "Appointment of Representatives" form;
* ACWDL 94-99: Required Appointment of Representative Form;
* ACWDL 94-70: Authorized Representatives with Durable Powers of Attorney;
* ACWDL 94-62: Long-Term Care and Incompetent Medi-Cal Applicants;
* ACWDL 94-42: Non-Profit Agencies Acting as Authorized Representative;
* ACWDL 93-84: Authorized Representatives; and
* ACWDL 90-01: Draft regulations on Implementation of the Spousal Impoverishment Provisions of the Medicare Catastrophic Coverage Act of 1988 Relating to Property. Sections 50142.5, 50147, 50154, 50157, and 50179 on screening, assessment, face-to-face interview, and notices of action.

The non-institutionalized community spouse or representative of the incompetent LTC person **MUST** sign all forms, provide verification, and attend the face-to-face interview. The county where that community spouse or applicant/beneficiary representative resides shall be the County of Responsibility. **The responsible county is not determined by the county residence/location of the Authorized Representative appointed by a competent community spouse, responsible relative, or other knowledgeable representative.**

Example 1: An non-institutionalized community spouse resides and maintains a home in County A. He/she applies in County A for the incompetent institutionalized spouse who is in an LTC facility in County B. County A shall accept the application, conduct the face-to-face interview with the non-institutionalized community spouse, and determine eligibility for the institutionalized spouse.

At the time of application, the couple's financial/resource information is used to compute the Community Spouse Resources Allocation (CSRA). If the non-institutionalized community spouse requests Medi-Cal benefits, eligibility shall be determined at the same time. [Reference: ACWDL 90-01, draft regulations, Section 50490 et. seq., and ACWDL 90-03].

County A, where the non-institutionalized community spouse lives may retain the case for continued eligibility since the institutionalized spouse is unable to provide information.

Example 2: The individual is in a hospital in County A and is being released to an LTC facility in County A. The individual is incompetent and unable to apply for Medi-Cal on his/her own. The individual's adult child, who lives in County B applies for benefits in County B on behalf of the LTC parent. County B shall accept and process the Medi-Cal application, assist the adult child in gathering information, determine initial eligibility, and grant benefits to the LTC applicant. County B shall retain the case because the adult child is the beneficiary representative acting on the beneficiary behalf for continued eligibility in reporting changes to CWD.

If the LTC applicant in this situation is competent but incapacitated, County B shall accept the application from the adult child, contact County A, and forward the application/information to County A. County A staff shall assist the LTC applicant with completing the Statement of Facts (MC 210), conduct the face-to-face interview, review the rights and responsibilities, and determine initial eligibility for the LTC applicant in County A.

If the LTC beneficiary becomes incompetent and the adult child becomes the beneficiary's representative, counties shall work with the adult child to determine in which county the continued eligibility case shall be retained.

Example 3: The beneficiary enters an LTC facility due to deteriorating physical and mental health. The beneficiary has family members in County A assisting with his/her personal/financial affairs. After three months, the family finds an LTC facility in County B that would better serve the needs of the beneficiary and moves the beneficiary to that facility in County B. The beneficiary's income and resources have not changed. The family requests that the beneficiary's Medi-Cal case remain in County A. County A shall honor the family's request and have the continued Medi-Cal case retained in County A.

Example 3 illustrates that there are situations when a beneficiary representative would move an LTC beneficiary from one facility to another within a short period. Keeping the case in the original county as specified would eliminate the excessive paper work involved with multiple intercounty transfers when county staff are working with a representative who handles the affairs of an **incompetent** beneficiary.

4. PERSON(S) WITH A FAMILY

When an individual's eligibility is determined as part of a Medi-Cal Family Budget Unit (MFBU), the County of Responsibility shall be the county where the family lives and maintains a home. [Reference: Title 22, CCR, Section 50371 and MEB Procedures Manual - Article 8]

Example: An individual is involved in an automobile accident and hospitalized in County A. The individual is expected to remain hospitalized for less than 30 days. The individual has a spouse and two children living in County B and that the family is an intact family, the County of Responsibility shall be County B. The individual is a member of the MFBU with the spouse and their children. The individual's eligibility is based on the family's circumstances and his/her share of cost is based on the family's income.

5. PERSON WITH NO FAMILY

a) When a person's eligibility is not determined as part of an MFBU, or not based on the family's income, the County of Responsibility is the county where the person lives and maintains a home.

Example 1: Ms. Smith is 69 years old and receives Medi-Cal benefits under the Medically Needy--Aged program. She maintains her home in County A but has adult children in other counties and visits them regularly. County A is the County of Responsibility because Ms. Smith is in an MFBU by herself and her adult children's income is not used to determine her share of cost.

Example 2: An individual is hospitalized in County A. The individual has an ex-spouse and children living in County B. The individual has been living, working, and maintaining a home in County A for two years. The County of Responsibility shall be County A because the individual is no longer considered a member of the ex-spouse's MFBU. In determining the County of Responsibility, the individual would be considered a person with no family.

Example 3: The Joneses have a home in County A. Mr. and Mrs. Jones decide to end their marriage. Mr. Jones lives in County B and Mrs. Jones and the children remain in the home in County A. County A is responsible for Mrs. Jones and the children. County B is responsible for Mr. Jones because Mrs. and Mr. Jones are no longer living together. [Reference: Title 22, CCR, Section 50351(b)(3) and MEB Procedures Manual - Article 8]

In this situation, there is no "marital tie" and Mr. Jones' income is not used to determine Mrs. Jones' or the children's share of cost.

b) When an individual's residence or identification is unclear, the County of Responsibility is determined by the physical presence of the individual. The individual shall be treated as a person with no family.

Eligibility staff shall review MEB Procedures Manual - Article 4I for instructions on **Diligent Search** when an individual has no identification and is comatose/incompetent, and there is no friend, relative, private or public guardian/conservator to assist the individual with the application for benefits.

Example 1: An unidentified comatose patient is hospitalized in County A. The patient has no identification and the hospital staff have no information on the individual. County A is the County of Responsibility until identification is obtained and residency is verified.

Example 2: An unidentified individual is hospitalized in County A. Hospital staff requested Medi-Cal benefits on behalf of the patient. County A eligibility staff followed MEB Procedures Manual - Article 4I and found that the patient has a spouse and children living in County B who are not on Medi-Cal. County A shall forward the SAWS 1 to County B since County A does not have enough information to determine initial eligibility. County A shall inform the spouse to contact County B to follow-up with the application process by completing the MC 210, attending the face-to-face interview, and providing verifications for eligibility determination. The individual is a member of the MFBU with the spouse and children, and the family's income is used to determine the MFBU's share of cost if the individual is expected to remain hospitalized for less than 30 days.

6. DECEASED PERSON

The County of Responsibility for a deceased person is the county where the person was living at the time of death.

Example: A person was admitted to a hospital in County A to receive emergency medical treatment. The person died in the hospital. The person was living in County B at time of death. County B is the County responsible for taking the application, determining eligibility, and issuing benefits for the deceased person.

If the deceased person's family or representative applies in any county within the State, the county in which the applicant representative applies in shall accept the application and process the application under the courtesy application procedures.

7. TEMPORARY ABSENT

When an applicant/beneficiary is temporarily absent from the home/state, the County of Responsibility is the county where the applicant/beneficiary maintains his/her home.

Example 1: The individual maintains a home with his spouse and children in County A. The daily commute to work from County A (his home) to County B is three hours one-way. The individual rents a room in County B to sleep from Monday through Thursday but he returns home to County A on his days off and holidays. County A is the County of Responsibility because he is temporarily absent from home due to employment. The individual is a member of the MFBU with his family and his income is used to determine the family's share of cost. [Reference: ACWDL 90-01, draft regulations, Section 50071]

Example 2: The individual is vacationing out of state and becomes ill. The individual is hospitalized and released one month later. The individual returns home to County A and applies for retroactive Medi-Cal benefits. The County of Responsibility for issuing retroactive Medi-Cal benefits shall be County A, where the individual maintains a home. [Reference: ACWDL 90-01, draft regulations, Section 50071; Title 22, CCR, Sections 50321, and 50323]

8. PERSON UNDER 21 YEARS OF AGE

When determining the County of Responsibility for a person under 21 years of age, parental control and the person's tax dependent status shall be evaluated. Parental control for purposes of determining the County of Responsibility is the authority of the parent(s) to make decisions on the child's behalf, whether or not the control is actually exercised. A child who is away at school but returns home on some weekends, holidays, or vacations and is subject to parental control is considered temporarily absent from the parents' household, regardless of the duration of the absence.

If a child is not living at home, between 18 to 21 years of age, is not claimed as a tax dependant, and is not subject to parental control, he/she is not considered living in the parents' household. [Reference: Title 22, CCR, Sections 50030 and ACWDL 90-01, draft regulations, Section 50071(a)(3)]

a) For a person who is under age 21, living away from home, and claimed by his/her parents as a dependent for tax purposes, the County of Responsibility is where the claiming parents live if the parents live in the State. [Reference: Title 22, CCR, Section 50373]

Example: A 19-year-old applied for Medi-Cal in County A. During the interview, the applicant informs the eligibility worker that his/her parents live in County B and claim him/her as a tax dependent. County A shall deny the application unless the applicant is applying for sensitive services under minor consent provisions. County A shall inform the applicant that if he/she wants full-scope benefits, his/her parents must file an application in County B for him/her.

b) A person (child) is between age 18 and 21 living in California but his/her parents, who claim him/her as a tax dependent, live out-of-state. The County of Responsibility is where the child lives but the parents must complete the MC 210, provide the county with information/verification, and cooperate with county staff in the child's eligibility determination

process. The county where the child is physically present shall contact the child's parents and ask the parents to complete the application and grant benefits to the child if eligibility conditions are met. [Reference Title 22, CCR, Section 50320 (c)]

Example: The applicant is an 18-year-old attending school in California. The applicant's parents live in the state of Oregon but he/she is the parents' tax dependant. The parents shall apply for the child if he/she is not a married child with children because the child is claimed as a tax dependent of his/her parents. The County of Responsibility is where the child resides because his/her parents live out of state. [Reference: Title 22, CCR, Section 50351(c)(1) and (2)].

c) The applicant is under age 21, living away from home and does not have information on his/her tax dependent status. The application for Medi-Cal shall be accepted in the county where the applicant lives.

Example: A 17-year-old applicant lives in County A. The applicant states that he/she is living away from the parents' home and self-supporting. The applicant does not know if his/her parents claim him/her as a tax dependent. County A is the County of Responsibility for eligibility determination because County A is where the applicant is living. [Reference: Title 22, CCR, Sections 50030 and 50351(c)(1) and (2)]

9. OUT-OF-HOME PLACEMENT

a) Public Agency/Government Representative

When a person is placed by a government agency/representative into a foster care home, board and care home, or a facility (See Glossary in MEB Procedures Manual - Article 3A), the County of Responsibility is where the placement agency is located if the public agency is the appointed guardian/conservator of the person.

A government representative is an employee of an administrative agency for a local, state, or federal government. The employee may be a public guardian/conservator or social worker who has placement responsibility of the person.

If the county where the foster care home, board and care home, or a treatment facility is located accepts a transfer of guardianship/conservatorship, then the County of Responsibility shall be where the beneficiary is living. **The County of Responsibility remains with the placement county until the county agencies work out the transfer/jurisdiction agreement.**

Example 1: The beneficiary has a public guardian in County A. The public guardian places the beneficiary into a County B facility. County A is the County of Responsibility because it is where the public guardian's office is located. [Reference: Title 22, CCR, 50127(a)]

If County B, where the beneficiary is living, accepts the transfer of guardianship, then County B becomes the County of Responsibility.

Example 2: The beneficiary has a public conservator and is in an LTC facility in County A. The public conservator transfers the beneficiary to a County B facility because the County B facility can better serve the beneficiary's needs. County A remains the County of Responsibility. [Reference ACWDL 90-01 draft regulations, Section 50125(1)(A)]

Example 3: A child is placed by County A's Department of Social Services into a foster care home in County B. County A continues as the County of Responsibility for the child. If County A has petitioned the court to transfer foster care responsibility to County B, County A shall remain as the County of Responsibility until the transfer is approved by the appropriate agencies. [Reference: ACWDL 90-01, draft regulations, Section 50125(1)(B) and 50373]

b) Private Agency/State Employed Person

When a person is placed into a board and care home, group home, or treatment facility by a guardian, person employed by a private agency or the state to act as guardian/conservator for the person, the County of Responsibility shall be where the board and care home or treatment facility is located unless a person's eligibility is based on the family's income or is determined as a member of an MFBU which includes the family.

Example 1: An individual has no family. The Court employs a person, who lives in County A, to act as the conservator for the individual. The conservator oversees the individual's personal/financial affairs and files periodic reports about the individual with the Court. The conservator is authorized by the Court to make decisions for the individual. The conservator finds a facility in County B that meets the needs of the individual and places the individual in the County B facility. County B is the County of Responsibility because a court appointed conservator is not an employee of a public agency. [Reference: Title 22, CCR, 50127 (b)]

Example 2: The beneficiary is in a private rehabilitation facility in County A and released by his rehabilitation facility physician to a board and care home in County B. The eligible person does not have a public guardian/conservator and is not under the conservatorship of a public agency. County A shall initiate an intercounty transfer to County B. The person's placement into a board and care home is privately arranged by the individual's physician. [Reference: Title 22, CCR 50127(3)]

Example 3: The child is temporarily absent from the home and is in a treatment facility in County A. The child's parents and siblings are living in County B and receiving Medi-Cal benefits. County B is the County of Responsibility

because the child's eligibility is part of the MFBU containing the family and his/her eligibility is based on the family's income/circumstances. [Reference: ACWDL 91-28 draft regulations, Section 50377(e)]

Example 4: The beneficiary is developmentally disabled and is receiving ABD-MN Medi-Cal benefits. The Regional Center for the Developmentally Disabled in County A is the assigned representative payee for the beneficiary. The beneficiary now is to live in a group home in County B. County B becomes the County of Responsibility because it is where the group home is located.

c) County Mental Health Agency or Regional Center for the Developmentally Disabled

When a person is screened and placed into a State hospital by a County Mental Health Agency or Regional Center for the Developmentally Disabled, **the County of Responsibility is where the State hospital is located.**

Example 1: The person has no family. The person is evaluated by County A Mental Health Agency and placed into a State hospital in County B. County B is the County of Responsibility because the State hospital is located in County B. [Reference: Title 22, CCR, Section 50129]

Example 2: The beneficiary receives Medi-Cal benefits from County A. The beneficiary is placed into a State hospital in County B by the Regional Center for the Developmentally Disabled. County B is the County of Responsibility and beneficiary will continue to receive benefits. An intercounty transfer to County B shall be initiated by County A if the beneficiary is receiving Medi-Cal only benefits. [Reference: Title 22, CCR, Section 50129]

d) Long-Term Care after Release from a State Hospital

When a person is placed into an LTC facility after release from a State hospital, the County of Responsibility is the county where the LTC facility is located.

If the person was placed into the State hospital by a public guardian/conservator and the public agency continues to have guardianship/conservatorship of the person, refer to examples on page **3C-7** for public agency placement because the County of Responsibility is where the public agency is located.

If the person's eligibility is determined as part of an MFBU with another family member or based on the family's income, refer to examples for person with a family on page 3C-4 in determining the County of Responsibility. [Reference: Title 22, CCR, 50131(a)(2)]

If the person has a spouse or representative who is acting on his/her behalf, refer to examples under LTC on page 3C-2.

3D–INTERCOUNTY TRANSFERS (ICT)

1. LEGISLATIVE BACKGROUND

There is no federal requirement to transfer the Medicaid case from one county to another when a Medicaid beneficiary changes county residency within the state (California). Federal requirements under 42 CFR 435.930 specify that the state must furnish Medicaid promptly to beneficiaries without any delay caused by administrative procedures and **continue** to furnish Medicaid regularly to all eligible individuals until they are found ineligible.

A Medicaid beneficiary's change of county residence does not affect his/her Medicaid eligibility unless the change of residency is established in another state or country. The state must administer the Medicaid program statewide with equitable standards and ensure the Medicaid plan is in continuous operation in all local offices. The state's policies and procedures must ensure that eligibility is determined in a manner consistent with simplicity of administration and in the best interest of the applicant and beneficiary. [Reference: 42 CFR 431.50 and 435.903]

The DHS, is the supervisory agency of California's Medicaid (Medi-Cal) program, adopted the statute that requires **when a beneficiary changes county residence within the State, it is the beneficiary's responsibility to notify the county issuing benefits of the move and to apply for a redetermination of eligibility in the new county of residence.** The county where the beneficiary has moved to is responsible for determining his/her continued Medi-Cal eligibility.

2. MEDI-CAL ONLY PROGRAMS (INCLUDING SIX-MONTH TRANSITIONAL MEDI-CAL)

When a beneficiary notifies the county that he/she has moved to another county to make his/her home, the county of the beneficiary's former home (first county) is responsible for issuing benefits until the transfer period expires. The county in which the beneficiary is making his/her home (second county) becomes responsible when the transfer period ends. **The transfer period ends the last day of the month after the 30-days notification from the first county to the second or subsequent (third county)counties.**

The Statewide ICT Simplification Demonstration Project (under the auspices of the State Department of Social Services) currently in effect will expire on April 30, 1996. The intent of the ICT Simplification Project is to reduce the amount of paperwork involved with a transfer from one county to another and to allow the counties the flexibility in shortening the ICT period. The State DHS does not anticipate any changes in the ICT regulations in Title 22, CCR until a review of the Simplification Project is completed. [References: DHS ACWDL 94-58 and CDSS ACL 94-39 Intercounty Transfer Simplification Demonstration Project]

When the beneficiary moves from the first county to the second county within the state and wishes to continue receiving benefits, the first county shall initiate an ICT to the second county within 7 calendar days after having received notification of the beneficiary's new address. The first county shall inform the beneficiary in writing of his/her responsibility to apply for a redetermination of eligibility in the second county before the expiration of the transfer period. The first county shall complete and mail the Notification of Intercounty Transfer Form (CA 215) (5/94) to the second county accompanied by information and/or documents necessary for the second county to process continued eligibility for the beneficiary.

The ICT Simplification Demonstration Project makes the transfer process easier and less cumbersome than the current regulations require. County staff are reminded that there will be circumstances that warrant more information/documentation be included in the transfer. Regulations exempt persons who have a government representative, such as a public guardian, acting on their behalf, as well as the aged, blind, and disabled, from the face-to-face interview requirement at redetermination. [Reference: Title 22, CCR, Sections 50157 (b), (d)(2), and 50189 (d)]

If the beneficiary moves to another (third) county to make his/her home before the expiration of the transfer period to the second county, the first county shall inform the second county that the transfer is cancelled. The first county shall send the new county (third county), where the beneficiary now lives, a copy of the CA 215 with the new discontinuance date and all required documentation. The first county shall inform the beneficiary of the newly established transfer period with the third county. The first county shall notify the beneficiary of his/her responsibility to apply for a redetermination with the third county before the expiration of the new transfer period.

Example: On June 1st, the Smith family notifies the first county that they are moving to the second county. On June 5th, the first county initiates an ICT to the second county and notifies the second county that Medi-Cal benefits for the Smiths will end on July 31st. On June 30th, the Smiths notify the first county that they have moved to another county (the third county). The first county shall notify the Smiths that their ICT to the second county is canceled and that a new transfer period is established with the third county.

On July 1st, the first county cancels the ICT to the second county and initiates a new ICT to the third county. The first county notifies the Smiths that they will continue to receive benefits from the first county until August 31st and that they must apply for a redetermination with the third county before the transfer period expires.

3. MANAGED CARE INFORMING

Medi-Cal Managed Care has affected beneficiaries' options in seeking treatment from providers of choice. Beneficiaries who move from one county to another may not have knowledge of their medical treatment options under their specific plans. Therefore, when the county is notified of a beneficiary's new county of residence, CWD staff in Managed Care Expansion counties shall inform the beneficiary that he/she shall contact his/her health plan representative to obtain disenrollment and out-of-area service information from his/her current health plan. If a beneficiary needs medical treatment during the transfer period, CWD staff must tell the beneficiary to contact and direct health plan questions to his/her health plan customer service representative.

Under Managed Care Expansion, a beneficiary who is enrolled in a **County Organized Health Systems** (COHS) plan is automatically disenrolled when he/she becomes eligible in the new county of residence (second county). The beneficiary is not required to disenroll from the first county's COHS plan. During the transfer period, a beneficiary who needs medical care in his/her new county of residence must obtain out-of-area authorization from the first county's health plan.

For the beneficiary who resides in a **two-plan model** county and moves to another county, the beneficiary remains in the first county health plan until he/she is disenrolled from the first county health plan. If the beneficiary needs medical care in the new county of residence during the ICT period, the

new provider in the new county of residence must obtain out-of-county authorization from the first county health plan. The beneficiary must disenroll from the first county's health plan. [Reference: ACWDL 94-43 Disenrollment from Health Care Plans]

4. FILE CLEARING - MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

Before granting continued eligibility to a beneficiary on an ICT, the second county shall conduct a file clearance of beneficiary information on the MEDS. The purpose of file clearing is to eliminate duplicate records and/or change incorrect information. If the beneficiary has any records on MEDS under a pseudo Social Security Number (SSN), an incorrect SSN, an incorrect date of birth or a misspelled name on MEDS, these records must be merged or fixed. If file clearing is not completed by the second county before putting the beneficiary on MEDS, MEDS may generate a new record for the beneficiary or reject the second county information. The first county's Medi-Cal case will continue on MEDS.

When the second county assumes case responsibility prior to the expiration of the transfer period, the second county shall complete an **MEDS EW05 Transfer of County of Responsibility** online transaction. The EW05 transaction is used to transfer responsibility for a beneficiary's case from one county to another. Staff shall review the MEDS Network User Manual, Chapter 10 for instruction on the EW05 usage and processing.

Staff are reminded that before a county can take control of the beneficiary's MEDS record from another county, staff shall verify a beneficiary's health plan status on MEDS. For a beneficiary who is enrolled in a county designated Medi-Cal Managed Care Health plan, he/she must first disenroll from the health plan.

5. LONG-TERM CARE (LTC)

An LTC beneficiary's move from County A facility (first county) into County B (second county) facility **MAY** not require an ICT. If the LTC beneficiary is incompetent and he/she has a community spouse or representative handling his/her affairs, the continued Medi-Cal case may be retained in the community spouse or representative's county of residence (See County of Responsibility, LTC examples on page 3C-2).

If an ICT is required, but there are no changes on the beneficiary's income or property when the first county transfers the case to the second county, the second county may use the Redetermination of Benefits for LTC Beneficiaries (MC 262) and not require the beneficiary or his/her representative to complete another MC 210 or provide verifications. The first county shall forward a copy of the MC 210 with other required documents/verifications to the second county. This will simplify the paperwork required and expedite the redetermination process for the beneficiary or his/her representative.

6. FOUR-MONTH CONTINUING MEDI-CAL COVERAGE

When a family receiving Medi-Cal benefits under the four month continuing Medi-Cal coverage moves from the first county to the second county, an ICT must be initiated by the first county to the second county. The first county is responsible for case activities and benefit issuance until the last day of the final month in which eligibility exists for the family under the four-month continuing Medi-Cal coverage. If a beneficiary becomes ineligible during the transfer period, the first county is responsible for the

issuance of any notices to the beneficiary. The second county is responsible for determining new Medi-Cal eligibility under other programs when the four-month eligibility period ends. Through mutual agreement, the first county may transfer the responsibility of all case activities to the second county before the four-month eligibility period expires.

Example: On January 1st, the Adams family began receiving their four-month continuing Medi-Cal benefits in the first county. In February, the Adams family notifies the first county that they have moved to the second county. The first County initiates an ICT to the second county but continues to be responsible for issuing benefits to the family until April 30th. In March, the second county contacts the family and informs them that they would be eligible for Medi-Cal under the Medically Needy program with a share of cost beginning May 1st. The second county approves benefits for the Adam's family and assumes responsibility effective May 1st.

7. PENDING DISABILITY DETERMINATION CASES

When a beneficiary or family is receiving Medi-Cal benefits and a member of the Medi-Cal Family Budget Unit (MFBU) has a pending application for Medi-Cal based on disability/blindness in their current county of residence, an ICT shall be initiated when they move to a new county of residence. The first county shall transfer the current case eligibility information to the second county while retaining the pending disability application information until the determination is received from the State Disability Evaluation Division (DED). Upon receipt of the DED disability determination , the first county shall determine eligibility within 14 calendar days for the retroactive period and forward the blindness or disability documentation to second county.

Example: A family of four with no AFDC linkage. Mr. and Mrs. are not eligible. Their two children, who are under 18 years of age, are eligible for benefits as Medically Indigent (MI) children. Mr. has filed an application for a disability-linked Medi-Cal evaluation. On January 1st, the family notifies the first county that the family has moved to the second county and requests an ICT to the second county. The first county shall initiate the ICT to the second county and note on the CA 215 that Mr. has a disability evaluation pending with the DED. First county retains Mr.'s disability application information in the case file until a decision is received from DED. The first county's responsibility for administering the MI portion of the case ends on the last day of February.

The second county grants Medi-Cal benefits to the children effective March 1st. The eligibility worker from the second county notes on the case record that Mr. has a DED application pending and that the family may be eligible for benefits under the Medically Needy (MN) program if Mr. is approved for disability-linked benefits. On March 5th, the first county receives Mr.'s disability determination from DED that he is determined "disabled". The first county shall photocopy the DED information for the case record, determine eligibility, recompute share of cost (SOC) if applicable, and issue benefits to the family for the retroactive period before forwarding the disability documentation to the second county eligibility worker by March 19th.

When the second county receives the DED determination from the first county, the second shall determine MN eligibility, recompute SOC if applicable, and issue benefits to the family for March and continuing.