



## Medi-Cal Access Program (MCAP) Business Rules

# Table of Contents

<b>1. Eligibility Business Rules</b>	<b>3</b>
1.1 Who Can Apply	3
1.2 MCAP Eligibility Requirements	3
1.3 MCAP Application Processing	4
1.4 Gross Household Income & Family Size Determination	5
<b>2. MCAP Missing Information Rules</b>	<b>6</b>
2.1 MCAP Application	
2.2 Single Streamlined Application (SSA)	
2.3 Infant Registration Form (Only applies to the Medi-Cal Access Infant Program (MCAIP))	
<b>3. Denial Rules</b>	<b>10</b>
3.1 Denied Applications	10
3.2 Denying Applications Because No Health Plan is available	10
3.3 Safe at Home Program	10
<b>4. Enrollment Rules</b>	<b>11</b>
4.1 Beginning Date of Coverage	11
4.2 Enrolled Pregnant Applicants	11
<b>5. Disenrollment Rules</b>	<b>12</b>
5.1 Disenrollment from MCAP	12
5.2 Withdraw from MCAP	13
<b>6. Appeals</b>	<b>14</b>
6.1 Appeals to the Board	14
6.2 DHCS Adjudication of Appeals	14
<b>7. Contributions</b>	<b>15</b>
7.1 Subscriber Contributions	15
7.2 Applying Contributions	16
<b>8. Delinquency Rules</b>	<b>17</b>
8.1 Credit Reporting Agency	17
8.2 Delinquency and Credit Reporting	18
<b>9. Plan Transfer Rules</b>	<b>19</b>
9.1 Health Plan Transfers for Women Enrolled in MCAP	19
9.2 Health Plans Terminating a Contract in MCAP	19
<b>10. Change of Address</b>	<b>21</b>
<b>11. Financial</b>	<b>22</b>
11.1 \$125 Reimbursement	22
11.2 Refunds	24
11.3 MCAP Refund Timelines:	26
11.4 Administrative Credits	28
11.5 Payment Reversals	28

# 1. **Eligibility Business Rules**

## 1.1 ***Who Can Apply***

Applications may be received by the MCAP Program directly from applicants, or they may be received from Covered California. When Covered California receives an electronic or paper application, and it contains a pregnant woman applying for coverage who appears to qualify for the MCAP Program, it will be sent to the MCAP Program for evaluation. The following people can apply for coverage:

1. Pregnant woman 18 years of age or older who is applying on her own behalf;
2. A family member applying on behalf of a pregnant woman 18 years of age or older
3. Legal guardian or natural parent, foster parent, or stepparent with whom the pregnant minor (under 18 years of age) resides; or
4. Pregnant woman 18 years of age or younger who is an emancipated minor, or a minor not living in the home of a natural or adoptive parent, legal guardian, foster parent or stepparent

## 1.2 ***MCAP Eligibility Requirements***

1. California resident who is present with the intent to remain in California; and
2. A Modified Adjusted Gross Income (MAGI) calculation, as determined by CalHEERS, that is greater than 213% and up to and including 322% of the federal income guidelines ; and
3. Not a no-cost Medi-Cal or Medicare beneficiary at the time of application; and
4. Not covered by comparable private insurance benefits (exception: an applicant may have private insurance if the co-payments or deductible for maternity services exceeds \$500.00); and
5. Not be reimbursed by any health care provider or any state or local government entity for payment of the subscriber contribution and not have any health care provider or state or local governmental entity pay the subscriber contribution

### **1.3 MCAP Application Processing**

Applications that arrive at the MCAP will be screened for No-Cost Medi-Cal or MCAP. Applications may be received in the following ways:

- An applicant may submit an application to the MCAP P.O. Box
- Covered California may send applications to the MCAP via courier.
- Applications may also arrive at the administrative vendor's designated street address either through the mail, overnight delivery service or walk-in applications. Walk-in applications can be delivered at the AV address during regular business hours of 8:00am to 5:00pm Monday through Friday (excluding Holidays).

Refer to the SPE Business Rules for processing requirements. Applications screened to Medi-Cal shall be forwarded to the appropriate County Welfare Department (CWD). Applications screened income eligible for MCAP or incomplete applications shall be forwarded to the MCAP for final MCAP eligibility determination. All applications received at SPE will be sent to either CWD or the MCAP. The timeline for processing applications forwarded to MCAP is as follows:

1. Complete applications must be processed within 3 business days.
2. All applications are checked against the MCAP database to identify duplicates. A duplicate application is an application from the same applicant for the same pregnancy based on a matching name, SSN (if one is provided) and EDD. If the application is a duplicate application, the existing application number is assigned to the application. If not, a new application number will be assigned by the system.

If an applicant submits an incomplete application MCAP must process the application as follows:

- a) Send the applicant a letter within 2 business days of the determination of incompleteness requesting the necessary information or documentation.
  - b) MCAP must also attempt to contact the applicant 5 times by phone to obtain the missing information beginning on the 2<sup>nd</sup> business day on which the incomplete determination is made.
3. The MCAP must receive the necessary information to make the application complete within 17 calendar days of application receipt.
  4. The MCAP will send an income interface to CalHEERS for an income eligibility determination.
  5. MCAP will calculate the financial contribution after CalHEERS has calculated the monthly income and FPL.
  6. For applications returned from the CWD, if not already attached with the CWD return, MCAP will request the subscriber for a Notice of Action (NOA) if the CWD return is being denied.

- If a subscriber was denied MCAP coverage, and MCAP learns that the subscriber was denied Medi-Cal coverage as well, MCAP will request the subscriber for a NOA.

## **1.4 Gross Household Income & Family Size Determination**

Gross Household Income will not be determined by the MCAP. Instead, an interface will be sent to CalHEERS for an income eligibility determination based on a MAGI FPL calculation.

Family members will be captured based on what is provided by the applicant. The family size will then be determined by the CalHEERS interface based on MAGI rules. CalHEERS will use their family size and income determinations to calculate the FPL for the pregnant woman. This information will be communicated back to the MCAP, and will be used to determine eligibility.

### **1.4.1 Income and Income Deduction Calculation**

MCAP Income Calculation will be solely determined by CalHEERS. All income and deduction information will be sent to CalHEERS for each person that counts in the family size.

## 2. MCAP Missing Information Rules

The Missing Information processes described in this section will be followed for all applications received immediately and retroactive to October 1, 2013, for applications forwarded from Covered California.

The following tables list data elements and documentation that are considered to be “missing information” (MI) if not provided by the applicant on the MCAP application, Single Streamlined Application, or the Infant Registration Form. If any of the items are missing, up to five (5) phone calls would be placed with the applicant and a MI letter is to be sent as appropriate requesting the MI, per contract requirements.

The following sections provide the critical MI for the following documents:

Section 2.2.1 identifies critical MI for the MCAP Application.

Section 2.2.2 identifies critical MI for the Single Streamlined Application.

Section 2.2.3 identifies critical MI for the Infant Registration Form.

**D** indicates that an application will result in a denial if the information is not received within seventeen (17) calendar days from the date the application was received.

**W** indicates that the information needs to be submitted in writing with the applicant’s signature and date.

**P** indicates the information can be taken over the phone.

Please note: Effective December 1, 2013, the \$50 initial premium payment requirement and the Pregnancy Certification is no longer required for enrollment into the MCAP Program.

### 2.1 *MCAP Application*

Data Elements and Documentation	Deny if Missing	In Writing or By Phone
<b>Section 1: Pregnant Woman Information</b>		
Last Name	D	P
First Name (middle initial)	D	P
Birthdate		P
Street Address	D	P
Phone Number		P
City	D	P
State		P

Zip Code		P
EDD	D	P
Number of Babies Expected	D	P
Do you or anyone in your household smoke? YES/NO		P
<b>Section 2: Insurance Information and Choice of Health Plan</b>		
Need a Yes or No to “At the time of application, do you have health insurance”	D	P
If Yes to “At the time of application, do you have health insurance”, then need a Yes or No to “Does the insurance cover your pregnancy”.	D	P
If Yes to “Does the insurance cover your pregnancy”, then need a dollar amount for “maternity-only deductible or co-pay”	D	P
1 <sup>st</sup> Choice of health plan	D	P
<b>Section 3: Family Size and Income</b>		
Need a Yes or No to “Are you married to the pregnant woman” if “Name of the father of baby” is filled in.		P
Need attestation of income information including frequency and amount (or attestation that there is no income).	D	P
Need to know whether each person on the application is a tax filer or dependent. Also need to know the tax filing status for each member in the last tax year and current tax year.	D	P
If Yes to either “Does the pregnant woman pay alimony or student loan interest” or “Does the father of the baby pay alimony or student loan interest”, then need amount and frequency of payment.		P
<b>Section 5: Authorization</b>		
Signature of Applicant	D	W
<b>MCAP Pregnancy Certification Form</b> The completed MCAP Pregnancy Certification Form page or equivalent document is required. If any of the following information is missing from either, then deny  <b>*The requirement for the Pregnancy Certification Form will end on November 30, 2013. Effective December 1, 2013, it will no longer be required.</b>	N/A	N/A
<b>Required Documentation</b>		
Proof of Income**	D**	W
Proof of Deductions**	D**	W

\*\*Proof of Income and Deductions will be requested if valid documentation is not provided with the application **and** :

- CalHEERS is unable to locate the members with income in the Federal or State sources **–OR–**

- CalHEERS is able to locate the members with income in Federal or State sources but the income found is not within MCAP guidelines.

## 2.2 *Single Streamlined Application (SSA)*

Required Data Elements on the Streamlined Application	Deny if Missing	In Writing or By Phone
<b>Infant Information:</b>		
Last Name	D	P
First Name (middle initial)	D	P
Birthdate		P
Street Address	D	P
Phone Number		P
City	D	P
State		P
Zip Code		P
EDD (In lieu of Last Menstrual Period)	D	P
Signature of Applicant	D	W

Required Data Elements and Documentation <u>NOT</u> on the Streamlined Application	Deny if Missing	In Writing or By Phone
Do you smoke? YES/NO		P
Does anyone in household smoke? YES/NO		P
Choice of MCAP health plan	D	P
<b>Insurance Info</b>		
If applicant checked question “If you have other health insurance or insurance through a job” we need the following information: <ul style="list-style-type: none"> <li>• Does the insurance cover pregnancy</li> <li>• Amount of deductible for maternity services</li> </ul>	D	P
<b>Authorization</b>		
Signature of Applicant for MCAP Declarations	D	W
<b>Required Documentation</b>		
Proof of Income**	D**	W
Proof of Deductions**	D**	W

\*\*Proof of Income and Deductions will be requested if valid documentation is not provided with the application **and:**

- CalHEERS is unable to locate the members with income in the Federal or State sources **–OR –**
- CalHEERS is able to locate the members with income in Federal or State sources but the income found is not within MCAP guidelines.

**2.3 Infant Registration Form (Only applies to the Medi-Cal Access Infant Program (MCAIP))**

Data Element	Deny if Missing	In Writing or By Phone
<b>Infant Information:</b>		
First Name	D	P
Last Name	D	P
Gender	D	P
Birth Date	D	P
Applicant Signature	D	W

### **3. Denial Rules**

#### **3.1 *Denied Applications***

When an MCAP application is denied, the following will occur:

1. A refund of any initial payment received must be refunded within the refund timelines described in Section 11.2.
2. The applicant will be notified by mail that their application has been denied.  
If the applicant's income is below MCAP guidelines, the following additional steps will occur:
3. MCAP must overnight the application and all related supporting documentation to the appropriate County Welfare Department. Transmittal document similar to SPE/HFP.
4. The applicant must be notified within 2 business days that her application has been forwarded to the County for an eligibility determination.

#### **3.2 *Denying Applications Because No Health Plan is available***

When an applicant resides in a zip code area that is not serviced by a participating MCAP health plan, the following steps will be taken:

1. MCAP shall contact the applicant by telephone to confirm that the residential address identified on the application is accurate. Up to five (5) call back attempts shall be made and documented in case notes.
2. In the event the applicant indicates that the residential address is correct, the application shall be denied.

#### **3.3 *Safe at Home Program***

The Safe at Home Program is a program that issues free P.O. Box addresses to certain individuals who meet the minimum criteria in order to maintain their safety.

3. P.O. Box is an acceptable resident's address if the applicant indicates they are participating in the Safe at Home Program.
4. Applicant may enroll into valid plans located in the zip code of their residential address while using a Safe at Home P.O. Box.

## **4. Enrollment Rules**

### **4.1 *Beginning Date of Coverage***

1. Coverage shall begin no later than ten (10) calendar days from the date the pregnant woman is enrolled in the Program. Coverage shall not begin if the pregnancy terminates prior to the effective date of coverage.
2. Coverage in the MCAP for the subscriber is for the pregnancy at the time of application and includes services following the termination of the pregnancy for sixty (60) days.

### **4.2 *Enrolled Pregnant Applicants***

The following occurs subsequent to an eligibility determination.

1. Subscriber receives an effective date 10 calendar days from date enrolled. The health plan will be sent the enrollment information the next working day.
2. Initiate welcome calls to all newly enrolled women in MCAP within 10-20 calendar days after effective date.
3. Mail welcome letter and packet within 2 business days.
4. Billing statements sent (12 months), except if paid in full with application.

## **5. Disenrollment Rules**

### **5.1 *Disenrollment from MCAP***

1. A subscriber can be disenrolled from the program and from the program's participating health plan when any of the following occur:
  - A. The subscriber requests disenrollment in writing.
  - B. The subscriber becomes ineligible because:
    - 1) The subscriber does not meet the residency requirement; or
    - 2) The subscriber has committed an act of fraud to circumvent the statutes or regulations of the program; or
    - 3) The subscriber is no longer pregnant on or after her effective date of coverage.
2. A subscriber will be notified by the program in writing of the disenrollment from the program and the reason for the disenrollment.
  - A. For sections 1.B.1 and 1.B.2, DHCS will request disenrollment with a notice of disenrollment sent by the 10<sup>th</sup> of the month disenrollment will occur at the end of the calendar month in which the request was received; otherwise, disenrollment will occur the following month.
3. All disenrollments under section 1 will be effective at the end of the calendar month in which the request was received, or at the end of a future calendar month as request by subscriber or DHCS.
4. As of January 1, 2014, disenrollment pursuant to 1.B.3 shall be effective at the end of the month of sixty (60) calendar days after the end of pregnancy date (i.e. birth outcome, miscarriage, etc.). (For example if the pregnancy ended on January 15, 2014, disenrollment will be effective March 31, 2014.)
5. Starting July 1, 2008, if an MCAP subscriber is no longer pregnant by the end of her first trimester, the subscriber contribution may be reduced to 1/3 of the full 1.5% contribution. To be eligible for a reduction in contribution the following must be submitted at any time:
  - A. Documentation by a licensed or certified healthcare professional. The documentation must include; Date Pregnancy Ended, Health Care Professional's First and Last name (printed), Signature of Health Care Professional and Medical Title of Health Care Professional.
  - B. Notification from a health plan that the subscriber is no longer pregnant is acceptable. The notification from the health plan needs to only include the subscriber's first and last name and date subscriber is no longer pregnant.

NOTE: "First trimester" means the first 13 weeks of a 40-week, full-term pregnancy.

6. If the subscriber cannot be contacted by letter or phone to obtain the birth outcome information, the subscriber shall be coded as "disenrolled" sixty (60) calendar days after the estimated date of delivery per the first day of the last menstrual period established during the application process. In the monthly data reporting, the contractor notifies the State and notifies the affected health plan of the disenrollment. A written "disenrollment" letter is sent to the applicant with a detailed explanation of the action taken including the effective date of disenrollment.
7. Once a subscriber is disenrolled, the subscriber cannot be re-enrolled for the same pregnancy.

## **5.2 Withdraw from MCAP**

1. A subscriber will be withdrawn from the program and from the program's participating health plan as never effective when any of the following occur:
  - A. The subscriber is no longer pregnant prior to her effective date of coverage; or
  - B. The subscriber requests in writing to be withdrawn from the program prior to her effective date of coverage.
2. A subscriber will be withdrawn from the program pursuant to section 1.A. and shall take effect upon the date that would have been the effective date of coverage.
  - A. If notification to the program is received after the effective date, documentation by a licensed or certified healthcare professional must be submitted indicating the date of the early end of pregnancy.
  - B. If notification is received prior to the effective date of coverage, documentation by a licensed or certified healthcare professional is not required.
  - C. If the birth outcome or Infant Registration form is received before or after the effective date.
3. A subscriber will be withdrawn from the program pursuant to section 1.B. only if the request is received prior to her effective date of coverage and shall take effect upon the date that would have been the effective date of coverage.

## **6. Appeals**

When a subscriber is dissatisfied with any action, or inaction of the program's participating health plan in which she is enrolled, the subscriber shall first attempt to resolve the dispute with the participating health plan according to its established policies and procedures, which are explained in each plan's Evidence of Coverage.

### **6.1 *Appeals to the Board***

1. If a subscriber is dissatisfied with any action or failure to act which has occurred in connection with a participating health plan's coverage the subscriber's remedy shall be to file an appeal with the Board.
2. In addition, the following decisions may be appealed to the Executive Director only:
  - a. A program determination as to eligibility of any applicant.
  - b. A program determination to disenroll a subscriber or infant from the program.
  - c. A program determination to deny a subscriber request or to grant a participating health plan request to transfer the subscriber to a different participating health plan.

An appeal must be filed in writing with the Executive Director within 60 calendar days of the action, failure to act, or receipt of notice of decision being appealed. An appeal must include a copy of the letter regarding a decision being appealed or a written statement of the action or failure to act, a statement from the applicant as to what is being disputed and the requested resolution, and any other relevant information the applicant wishes to include.

DHCS will adjudicate an appeal of a program determination related to an eligibility decision or disenrollment decision. The administrative vendor shall forward an appeal, which meets these guidelines to DHCS within 5 business days. The administrative vendor adjudicates all other correspondence (i.e., new income documentation).

### **6.2 *DHCS Adjudication of Appeals***

Once DHCS makes a determination to enroll, disenroll, withdraw or other action, the administrative vendor will be notified using the attached sample communication forms. Upon receipt, the administrative vendor must process the request within 2 business days and provide confirmation to DHCS that the action is complete.

## **7. Contributions**

### **7.1 *Subscriber Contributions***

1. As of December 1, 2013, a subscriber contribution is not required in order for a subscriber to be enrolled in the MCAP.
2. Subscriber contributions are 1.5% of the family's annual net income.
3. Contributions may not be made on behalf of the subscriber by any State or local government.
4. Contributions may not be made on behalf of the subscriber by any health care provider or health insurer.
5. Contributions may be made on behalf of the subscriber by any federally recognized California Indian Tribal Government who is a member of the tribe. Go to [www.doi.gov/leaders.pdf](http://www.doi.gov/leaders.pdf)
6. All subscriber contributions are deposited in the bank collections account and posted to Oracle Financials.
7. Any payments received that are not made payable to the MCAP will be returned to the payer and not be deposited.

#### **7.1.1 For women enrolled in MCAP**

Total cost for the program is 1.5% of adjusted annual household income. This amount can be paid in 12 monthly installments. A \$50 discount is given if the entire 1.5% cost is included with the application.

1. Subscriber contributions net of the initial payment are due in 12 equal monthly installments.
2. Billing statements shall be used to bill the subscriber's contribution over the 12-month period.
3. The difference of prepaid contributions received prior to being determined eligible and the annual contribution amount, up to \$75.00 short of the annual contribution amount, are due the first day of the month following enrollment into a health plan.
4. Monthly subscriber contribution payments are due the first day of the month following enrollment into a health plan.
5. Subscribers will receive a billing statement no later than 10 business days prior to the date the contribution payment is due.
6. Monthly subscriber contributions are paid by cashier's check, money order, personal check, credit card, western union, or EFT. Note: Payments by credit card, western union or EFT are postponed until after 7/1/04

7. If a woman applies for re-enrollment in the MCAP for a different pregnancy and has a balance due from the previous enrollment, the delinquent amounts do not have to be paid in full before enrolling.
8. There is no grace period for payments received after the invoiced due date.
9. Subscriber contributions paid that are equal to the total annual contribution amount are posted as paid in full in the month of payment. (i.e. no allocating payments over a 12 month period)

All infants born to subscribers enrolled on or after July 1, 2004 are enrolled directly into the HFP program. No MCAP contributions are billed or are due for these infants since they are no longer eligible for the MCAP.

## **7.2 Applying Contributions**

- Contribution amounts received will be posted in the order received to the oldest amount due (oldest invoice).
- Overlapping pregnancies: Each pregnancy is a separate charge with separate installment agreement. If an applicant is past due for a pregnancy and applies for coverage under the program for a subsequent pregnancy they will not be denied for the past due balance. Any payments made towards either pregnancy will be applied towards the oldest invoice. If the payment is not sufficient to cover both invoices for the month, invoice from the oldest pregnancy will be the priority.
  1. If the initial payment received with the application is equal to or greater than the annual contribution amount, then:
    - apply a \$50.00 administrative credit,
    - apply the initial payment to the balance of the annual contribution amount due, and
    - post the remainder on account for a refund.
  2. If the initial payment received with the application is equal to the annual contribution amount less a maximum of \$75.00, then:
    - apply a \$50.00 administrative credit,
    - apply the initial payment to the balance of the annual contribution amount due, and
    - bill the remainder as due the first day of the month following enrollment into a health plan.
  3. If the initial payment received with the application is less than the annual contribution amount minus \$75.00, but equal to or greater than the initial \$50.00 required contribution amount, then:
    - do not apply a \$50.00 administrative credit,
    - apply the initial payment to the annual contribution amount due, and

- divide the balance by 12. This is the monthly billable amount.
4. EFT Payments will be withdrawn and credited to the subscribers account each month for the full amount of the monthly contribution only.
- No discounts will be given for payment by EFT
  - Upon start up of the subscriber's request for EFT payment process, if the first EFT payment is withdrawn from the subscriber's bank account in the same month that the subscriber makes a payment, credit both payments to the subscriber's account and refund the duplicate payment upon request from the subscriber.

## **8. Delinquency Rules**

### **8.1 *Credit Reporting Agency***

At anytime if the subscriber is more than 3 months late in paying her MCAP contribution cost, she will be reported to a credit agency as past due for the entire

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amount of her contribution cost. She will not be disenrolled from the MCAP. Once the total cost is paid, the credit reporting agency will be contacted and the account will be noted as paid-in-full and a request to “delete” the delinquency record shall be submitted. Past due notices are sent by the administrative vendor at thirty (30), sixty (60), and ninety (90) days past due.

## **8.2 *Delinquency and Credit Reporting***

1. A 30 days past due notice shall be included on the monthly billing statement when the subscriber fails to pay a monthly subscriber contribution for 30 calendar days from the scheduled payment due date.
2. A 60 days past due notice shall be included on the monthly billing statement when the subscriber fails to pay a monthly subscriber contribution for 60 calendar days from the scheduled payment due date.
3. A 90 days past due notice shall be included on the monthly billing statement when the subscriber fails to pay a monthly subscriber contribution for 90 calendar days from the scheduled payment due date.
4. After the 90 days past due notice is sent to the subscriber and the subscriber has failed to pay the monthly subscriber contributions, the subscriber is reported to a credit reporting agency.
5. Credit reporting of subscribers who are 90 days delinquent will be monthly.
6. No disenrollment will occur for non-payment of subscriber contributions.
7. If the subscriber pays the past due balance in full with cash or cash equivalent, then the credit reporting agency is notified and instructed to delete the credit report item. The request to delete the credit reporting item will be processed in 3 business days.
8. If the subscriber pays the past due balance in full with a personal check, credit card, or EFT, then the credit reporting agency is notified and instructed to delete the credit report item. The request to delete the credit reporting item will be processed in 10 business days, but not before the payment is validated.

## **9. Plan Transfer Rules**

### **9.1 *Health Plan Transfers for Women Enrolled in MCAP***

1. A subscriber shall be transferred from one participating health plan to another if any of the following occurs:
  - A. The subscriber so requests, in writing, because the subscriber has moved and no longer resides in an area served by the participating health plan in which the subscriber is enrolled, and there is at least one other participating health plan serving the area in which the subscriber now resides that is accepting new enrollees.
  - B. The subscriber or the participating health plan so requests, in writing, because of failure to establish a satisfactory subscriber-plan relationship and the DHCS Executive Director determines that the transfer is in the best interests of the program, and there is at least one other participating health plan serving the area in which the subscriber resides that is accepting new enrollees.
  - C. The program contract with the participating health plan in which the subscriber is enrolled is canceled or not renewed.
2. The effective date of transfers pursuant to subsection (1.A.) of this section shall be:
  - A. Within seventeen (17) calendar days of receipt of the transfer request for the subscriber.
3. The effective date of transfers pursuant to subsection (1.B.) of this section shall be:
  - A. Within fifteen (15) calendar days from approval of the transfer request for the subscriber (MCAP mom).
4. The effective date of transfers pursuant to subsection (1.C) of this section shall be prior to the end of the contract.
5. An MCAP health plan transfer for a subscriber (MCAP mother) is effective ten (10) calendar days after the request is approved but within seventeen (17) calendar days from the receipt date of the request, or unless otherwise instructed by the DHCS. If the subscriber requesting the transfer is more than 30 weeks pregnant, prior approval from the new health plan and medical group/provider must be obtained before the transfer is approved by the DHCS.

### **9.2 *Health Plans Terminating a Contract in MCAP***

#### **Pregnant & Post-Partum Subscriber**

- Current plan is required to continue providing services to the subscriber throughout the pregnancy and 60-days post-partum.
- Subscriber has an option to transfer to one of the other existing MCAP participating plans. If she chooses to transfer and she is over 30 weeks pregnant, DHCS will coordinate with the new plan to ensure access to care.
  - Transfer of the subscriber is effective within 17 days of the request.

**9.2.1** **Directions for Anthem Blue Cross HMO in Alameda, Fresno, Sacramento, San Francisco, and Stanislaus counties; Anthem Blue Cross EPO in Monterey, San Mateo, Solano, and Yolo counties and Health Net NMO in Santa Clara, Santa Cruz, and Stanislaus counties.**

*Rules only effective for the contract effective February 1, 2009.*

**9.2.1.1** **MCAP SUBSCRIBERS**

1. If an existing MCAP subscriber is already enrolled in an MCAP plan that is listed in 10.2.2, the plan will continue to provide the MCAP subscriber with coverage in the following instances:

Any MCAP mother currently enrolled in a plan listed in 10.2.2 will remain enrolled in their plan with coverage ending 60 days after the pregnancy ends, regardless of their expected date of delivery or the actual date of delivery.

## **10. Change of Address**

1. A subscriber must notify the MCAP in writing within thirty (30) days if their resident address or their billing address has changed. They must send their written notification by mail or fax. A change of address may also be received over the phone by the call center.
2. The MCAP will notify their enrolled health plan of the change of address.
3. If a health plan receives a change of address and forwards it to the MCAP, MCAP must confirm the change with the applicant and determine if a health plan transfer is necessary.
4. Some address changes may require that the subscriber be transferred to another health plan because the health plan they are enrolled in does not serve the new county of residence. If the change of address reflects an out of state address, and it is not noted as a temporary address, the infant or subscriber should be disenrolled.

## 11. **Financial**

### 11.1 ***\$125 Reimbursement***

Each subscriber may be reimbursed up to a total of \$125 for PAID pregnancy-related services, which are received within 40 calendar days prior to the date a complete application is received and 90 days of the date of service.

Acceptable services that are received within the program time frames by the applicant from a provider that is outside the State of California or outside of the Country will still be reimbursed.

A subscriber, not a health care provider, must request this reimbursement in writing by mail or fax to the administrative vendor within 90 days of the date the services were received and shall include the following information:

1. A photocopy of an original bill including the name and business address of the person/entity providing the services.
2. Subscriber's name, address, date of birth and social security number (optional).
3. The date the subscriber received the services.
4. The type of services received by the subscriber.

A list of reimbursable pregnancy related services

- Pregnancy Test
- Pap smear
- Pre-natal Visit
- Blood Test
- Obstetric Panel
- Urinalysis (method utilized to perform procedure does not affect determination for eligibility for reimbursement. Example: UA by Dip stick/Tablet-Reagent for Glucose, Hemoglobin)
- Laboratory (Lab)/Laboratory (Lab) Test
- Ultrasonic exam
- OB/GYN pre-natal ultrasound level 2
- Antibody screen
- Pre-natal panel hemogram
- Cyto Pap Thin Prep
- Initial Obstetrical Exam
- Alpha-Fetoprotein(AFP)
- Estriol
- Human Chorionic Gonadotropin
- Chlamydia

- US, Transvaginal
- Prescription
- Blood Count
- Initial Comprehensive (1 x per pregnancy)
- Sexually Transmitted Diseases (STDs)
- Antepartum Care
- Health Education
- Initial Prenatal Office Visit;
- Pregnancy Initial Visit;
- Pregnancy Visit
- Prenatal Panel
- Prenatal Profile
- Echo Exam
- Echo Exam of Pregnancy or Sonogram
- OB Medical Care
- OB Lab/Radiology
- Venipuncture, Venepuncture, or Venopuncture
- Pregnancy Associated Plasma Protein – A (PAPP-A)
- V22.0 (Prenatal care supervision of normal fist pregnancy)
- V22.1 (Prenatal care supervision of other normal pregnancy)
- V22.2 (Pregnant state incidental)
- V23.0 (Supervision of high-risk pregnancy with history of infertility)
- V23.1 (Supervision of high-risk pregnancy with history of trophoblastic)
- V23.2 (Supervision of high-risk pregnancy with history of abortion)
- V23.3 (Supervision of high-risk pregnancy with grand multiparity)
- V23.4\* (Supervision of high-risk pregnancy with other poor obstetric history)
- V23.5 (Supervision of high-risk pregnancy with other poor reproductive history)
- V23.7 (Supervision of high-risk pregnancy with insufficient prenatal care)
- V23.8\* (Supervision of other high-risk pregnancy)
- V23.9 (Supervision of unspecified high-risk pregnancy)
  - Progesterone, Serum
  - TSH, Serum. H.S.; HEP B SURF ANTIGEN
  - V72.42 Pregnancy Test Pos
  - CTTOPATH, GYN, INTERP
  - HGC, Sefa Subunit, Onf, Serum
  - HCGQUANTBLOOD
  - Pap IG, Ct-Ng. Rfx HPV ASCU
  - UCG, DX 626.8, DX 640.93.
  - Abnormal Pap Code 795
  - 9467/26 Pulse Oximetry, Single
- Procedure Code 36415: Description of the procedure code is identified as one (or a combination) of the following:
  - Blood Drawing

- Venepuncture
- Venipuncture
- Venopuncture
- Or Collection of Venous Blood by Venipuncture
- Amenorrhea
- V72.40 – Pregnancy Test Unconfirmed
- Herpes Simplex Virus I, II
- Nuchal Translucency
- Absence of Menstruation
- RH Factor
- Handling/Collections with or without Other Billed Services
- PARVO B19 IGG/IGM
- Draw Fee, PSC SPEC
- Injection, RHO(D) IM
- Cephalexin

\*Any additional number following this code is acceptable

- A subscriber shall receive no more than \$125.00 in reimbursements for pregnancy related medical services received prior to enrollment into the MCAP.
- Reimbursements must be for the actual amount paid by the applicant up to \$125.00.
- Reimbursements will be made by check.
- Timeframe for issuing the reimbursement will be within 30 calendar days of the receipt of the request.
- Approved reimbursements will be used to satisfy payments where the subscriber is past due.

## **11.2 Refunds**

1. Refunds will be made by check
2. No refunds are given after the subscriber's effective date of coverage for any reason except for:
  - Withdrawals authorized by the DHCS
  - overpayments,
  - duplicate payments due to EFT startup, or
  - payments not intended for the MCAP.
3. Refunds are not made for 10 business days until all cash receipts are verified.

4. The minimum amount to initiate a refund is \$1.00
5. All refund will contain a brief explanation on the check stub of the reason for the refund.
6. The State may request refunds to be held from issuance
7. The system will have the capability of issuing refunds on demand which can be any amount over \$1.00 for over paid subscriber contribution amount.
8. No refund is given for any administrative credit.
9. All refunds will be mailed to the following addresses, if those addresses are available.

New Application

- 1<sup>st</sup> the Applicant's mailing address
- 2<sup>nd</sup> the Applicant's street address

Active or Inactive MCAP Subscriber

- 1<sup>st</sup> the subscriber's mailing address
- 2<sup>nd</sup> the subscriber's street address

Unidentified Payment

- mailing address on the envelope
- address on the check (if applicable)

Excess subscriber contributions are systematically refunded for the following reasons:

1. Denied eligibility--The applicant is found ineligible for MCAP
2. Overpayment--Any credit balance remaining on the subscriber's account after the annual subscriber contribution and the one time infant contribution is satisfied.
3. Withdrawal—The subscriber withdraws for the following reasons:
  - The subscriber is no longer pregnant and provides written notification that she is no longer pregnant.
  - The subscriber requests disenrollment and the written notification is received within 90 days after the effective date of coverage and no services were utilized (including the \$125 reimbursement).
4. Disenrolled--The subscriber becomes ineligible **before her effective date of coverage**.
5. MCAP Cap for Mothers-- Initial contributions received with applications after the program is capped.

6. Unidentified Subscriber contributions—Subscriber contributions that cannot be associated to an applicant or an active MCAP subscriber.
7. Excess family contributions are refunded on demand for the following reasons:
  - Upon subscriber request when a duplicate payment is made due to start up EFT payment processing.
  - Subscriber erroneously sends a payment not intended for the MCAP (e.g. rent, utilities, mortgage) and requests a refund
8. Refunds of \$1,000.00 or greater require two approvals, one of which will be a Maximus Financial manager.
9. Refund checks returned from the post office, where no other address is available to mail to the applicant/subscriber, are credited to the applicant/subscriber's account. After three years any receipts not returned to the subscriber are reported as unclaimed property. See HFP Unclaimed property rules.
10. Refund checks returned from the applicant/subscriber are credited to the applicant/subscriber's account.
11. Refunds will be processed in accordance with timelines established by the State.

### **11.3 MCAP Refund Timelines:**

1. Denied eligibility--The applicant is found ineligible for MCAP
  - Reason to hold payment before refunding
    - Hold refund until final eligibility determination is complete (time period includes call backs), and
    - Hold refund until payment is verified.
  - Amount of time to hold payment before refunding
    - Hold time –20 calendar days from payment receipt date to process application, make callbacks, and clear checks.
2. Withdrawal--The subscriber withdraws for reasons described in Section 11.2 #3
  - Reason to hold payment before refunding
    - Hold refund until payment is verified.
  - Amount of time to hold payment before refunding
    - Hold time –10 calendar days from payment receipt date
3. Disenrolled--The subscriber becomes ineligible before her effective date of coverage.

- Reason to hold payment before refunding
    - Hold refund until payment is verified.
  - Amount of time to hold payment before refunding
    - Hold time –10 calendar days from payment receipt date
4. MCAP Cap for Mothers-- Initial contributions received with applications after the program is capped.
- Reason to hold payment before refunding
    - Hold refund until payment is verified.
  - Amount of time to hold payment before refunding
    - Hold time –10 calendar days from payment receipt date
5. Unapplied Subscriber contributions--Subscriber contributions that cannot be associated to an applicant or an active MCAP subscriber.
- Reason to hold payment before refunding
    - Hold refund in case an applicant can be identified and eligibility determination is complete (time period includes call backs), and
    - Hold refund until payment is verified.
  - Amount of time to hold payment before refunding
    - Hold for 30 calendar days from payment receipt date
6. Unidentified Subscriber contributions--Subscriber contributions that cannot be applied or returned due to no identifying data available (i.e. money order with no FMN, Name, or address and no return address on the envelope.)
- Reason to hold payment before refunding
    - Hold refund in case an applicant can be identified and eligibility determination is complete (time period includes call backs), and
    - Hold refund until payment is verified.
  - Amount of time to hold payment before refunding
    - Hold for 30 calendar days from payment receipt date
7. Overpayment--Any credit balance remaining on the subscriber's account after the annual subscriber contribution and/or the one time infant contribution, if applicable, are satisfied.
- Reason to hold payment before refunding
    - Hold refund until payment is verified.
  - Amount of time to hold payment before refunding
    - Hold time –10 calendar days from payment receipt date

8. Subscriber request--When a duplicate payment is made due to start up EFT payment processing; or, Subscriber erroneously sends a payment not intended for the MCAP (e.g. rent, utilities, mortgage) and requests a refund.
  - Reason to hold payment before refunding
    - Hold refund until payment is verified.
  - Amount of time to hold payment before refunding
    - Hold time –10 calendar days from payment receipt date

#### **11.4 *Administrative Credits***

1. A \$50.00 administrative credit is given if the applicant submits a total payment equal to the total 1.5% annual contribution at the time she submits her application or before being determined eligible.
2. A \$50.00 administrative credit is given if it appears that the applicant is attempting to pay the total amount of the annual contribution in full, to qualify for the \$50.00 discount, and the payment submitted with the application is no less than \$75.00 short of the total 1.5% annual contribution amount. The remaining balance is due the first day of the month following enrollment into a health plan. The \$50.00 administrative credit will be reversed if the subscriber fails to pay the difference in full by the first day of the month following enrollment into a health plan.

#### **11.5 *Payment Reversals***

1. All payments returned which have not been honored will be debited to the subscriber's account.
2. The subscriber will be notified of the returned item.