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MEDI-CAL ELIGIBILITY MANUAL LETTER NO. 139

TO: Holders of the Medi-Cal Eligibility Manual

Enclosed are revisions to Article 23, Medical Support Enforcement Program, of the Medi-Cal Eligibility Manual.

Procedure Revision	Description
Article 23	Revisions to the Procedures for Medical Support Enforcement Program due to clarifications in policy and legal opinions.

Filing Instructions:

Remove Pages	Insert Pages
Article 23 Table of Contents Pages 1 and 2	Article 23 Table of Contents Pages 1 and 2
23A-1	23-A-1
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23I-1 through I-4	23I-1 through I-4

If you have any questions concerning a specific revision, please contact Ms. Elena Lara at (916) 657-0712.

Sincerely,

Original signed by

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosure

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23A. INTRODUCTION

1. PURPOSE

The Medical Support Enforcement Program provides that as a condition of eligibility for Medi-Cal, applicants, beneficiaries, or caretaker relatives must cooperate in medical support enforcement when there is an absent parent who may be responsible for their dependent child(ren)'s medical care, or in paternity establishment when there is a child born out of wedlock. These referrals for medical support enforcement will be made for all children under age 18 who are recipients of Medi-Cal or for whom Medi-Cal is being sought.

2. BACKGROUND

Title IV-D of the Social Security Act established the child and spousal support enforcement program. The Federal Deficit Reduction Act of 1989, the Consolidated Omnibus Budget Reconciliation Act of 1985, and the Omnibus Budget Reconciliation Act (OBRA) of 1987 amended sections 1902 and 1912 of the Social Security Act. These legislative changes required that, as a condition of Medi-Cal eligibility, applicants and beneficiaries must cooperate in medical support enforcement and paternity establishment. Assembly Bill 1422 (Chapter 806, Statutes of 1988) added section 14008.6 to the Welfare and Institutions Code to adopt, at the state level, the federal requirements.

Medical Support referrals are made to the Family Support Division/District Attorney (FSD/DA). Under California Civil Code, Section 4726, the court must consider that either the absent parent, custodial parent, or both parents provide medical insurance coverage to the child(ren) when medical insurance is available at no or reasonable cost. Section 4726 also requires the court and FSD/DA to secure health insurance through court and administrative orders in all child and medical support actions. Section 4726.1 permits the court to order the employer of the absent parent or other person providing health insurance to the caretaker parent to enroll the supported child in the available health insurance plan. Welfare & Institutions (W&I) Code, Section 11490, requires that medical insurance information be collected by the county FSD/DA offices and then forwarded to Department of Health Services (DHS).

The FSD/DA is responsible for enforcing medical support, in addition to obtaining information regarding the availability of health insurance when such information is not reported by the county welfare department. Health insurance coverage is required if it is available at no or reasonable cost to the parent(s). Federal regulations define "reasonable cost" health insurance as group or employer related health insurance, regardless of the service delivery mechanism. This includes health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

3. IMPLEMENTATION

The medical support enforcement regulations for DHS's Medi-Cal program were implemented by county welfare departments on July 1, 1993.

23B. CONDITION OF ELIGIBILITY

1. MEDI-CAL ONLY

The county must inform an applicant for or beneficiary of Medi-Cal only that, as a condition of eligibility, the applicant or beneficiary must:

- o Assign to the State the applicant's or beneficiary's rights to any medical support and payments;
- o Cooperate in obtaining medical support and payments;
- o Cooperate in establishing paternity for a child born out of wedlock for whom aid is requested;
- o Cooperate in identifying and locating the absent parent; and
- o Provide information about possible entitlement to medical support and payments available through any third party.

If the applicant or beneficiary is found ineligible for Medi-Cal because of the above, this will not affect the child(ren)'s Medi-Cal eligibility. The applicant can withdraw the application, close the case, or become an ineligible member of the Medi-Cal Family Budget Unit (MFBU).

2. AFDC/Edwards

A recipient of Aid to Families with Dependent Children (AFDC) who is discontinued from AFDC for refusal to cooperate in child support will receive Edwards Medi-Cal. In these cases, the AFDC applicant was referred to the FSD/DA for child support and medical support enforcement as a condition of eligibility for the AFDC program. The situation here is whether there is authority to automatically discontinue the caretaker parent from Medi-Cal at the same time the AFDC program discontinues cash aid for noncooperation if the caretaker parent refuses to cooperate in providing or obtaining paternity, child support, medical support, and/or third party liability information. The answer is **NO**, counties cannot **automatically** terminate Medi-Cal benefits for individuals whose AFDC assistance has ended. Counties must determine whether those individuals are eligible for Medi-Cal under other nonautomatic Medi-Cal categories. However, a **concurrent** determination of Medi-Cal eligibility meets the requirements of **Edwards** as long as the county fully documents that it is a **separate** determination and not part of the AFDC denial of benefits.

In other **Edwards** cases, upon review of the 210E, if the case is an absent parent situation or there is a child born out of wedlock, the county will **mail** the applicant/caretaker parent the medical support enforcement information. The caretaker parent may then agree to cooperate and sign the documents or can claim good cause for noncooperation. If the caretaker parent refuses to cooperate, follow procedures for noncooperation and refer the child(ren) for medical support enforcement.

Even though the AFDC eligibility worker is responsible for sending the case package of child support forms, the EW is responsible for ensuring that the medical support portions of these forms are filled out correctly for Medi-Cal. If needed, the counties can use the revised forms available in the DHS warehouse.

3. **DEPARTMENT OF SOCIAL SERVICES (DSS) CHILD SUPPORT PROCEDURES**

DSS child support procedures are to be found in the following:

- o DSS Manual of Policy and Procedures (MPP) Sections 12-100 through 12-908 and 43-200 through 43-203;
- o DSS Family Support Division (FSD) Letter No. 93-08, 3/12/93 Title IV-D Child and Spousal Support Program Procedure Manual.

23D. PETITION TO THE COURT

The county must notify each applicant or beneficiary placed in the following aid codes that the California Child Support Enforcement (IV-D) Agencies must, by law, petition to the court to include health insurance coverage in support orders when a child receives Medi-Cal. Referral in aid codes cited below will be for children under 18 with an absent parent or when a child is born out of wedlock. HOWEVER, NO UNDOCUMENTED PERSONS, NO PREGNANT WOMEN, AND NO ONE APPLYING FOR MINOR CONSENT SERVICES WILL BE REFERRED. Also, referrals for infants will be made after the 60-day postpartum period. (For explanation of absent parent situations, please refer to MEM Article 1-B.)

In situations where the applicant is filing for retroactive Medi-Cal only, no referral will be made. When the absent parent is incarcerated or institutionalized, no referral will be made.

In situations where the absent parent is already providing health insurance, no referral is necessary. Even though the child is covered by medical insurance, the child can be eligible if all Medi-Cal eligibility requirements are met, and the mother will have linkage based on the child. If the mother does not apply for the child or the child is ineligible for any reason, then the mother becomes ineligible for Medi-Cal because the child cannot be used to link the mother.

In on-going medical support cases, at redetermination or at any time, if there is any change in the case, it should be reported to the FSD/DA via Form CA 371. The FSD/DA should be advised of any changes in the case which involve a change in status such as discontinuance of eligibility, change in family composition, loss of health coverage, change in income, etcetera. If there are no changes in the case at redetermination, no report to the FSD/DA is necessary.

MEDI-CAL AID CODES

The following aid codes are the ones for which the Medi-Cal Eligibility Worker must refer the children with an absent parent.

7A	27	47	64	79
20	34	51	67	82
24	37	60	72	83

AFDC AID CODES

The following aid codes are the ones for which child support referrals, including medical support, should have already been made by the AFDC or Foster Care Intake Worker for AFDC or foster care cases.

30	33	40	45
32	35	42	

1. **PREGNANT WOMEN**

Medical support referrals will **NOT** be made on an unborn child until the end of the 60-day postpartum period of the mother. If the mother of the unborn has other eligible children in the MFBU, a medical support referral for these children will **NOT** be made until the end of the 60-day postpartum period of

the pregnant caretaker parent. If a pregnant caretaker parent has other eligible children in the MFBU with a different absent parent than for the unborn, a medical support referral will **NOT** be made on the children of the absent or unmarried parent(s) until the end of the 60-day postpartum period of the pregnant caretaker parent.

When a woman with a child(ren) has applied for Medi-Cal but refuses to cooperate in medical support and does not claim good cause, she becomes ineligible for Medi-Cal and designated as an ineligible member of the MFBU. The woman's child(ren) may be eligible for Medi-Cal if otherwise eligible and she has not withdrawn the application or asked to close the case. If this caretaker parent then becomes pregnant and applies for Medi-Cal, she may be eligible until her 60-day postpartum period ends. A referral for the caretaker parent and the new child can be made at the completion of the 60-day postpartum period.

If a caretaker parent has a child(ren) and has cooperated with medical support requirements, but then becomes pregnant, the medical support referral process should not be interrupted. The pregnancy should be reported to the FSD/DA, but no referral on the new child should be made until the 60-day postpartum period ends. The rule in on-going medical support cases is if there is any change in the case, it should be reported to the FSD/DA via Form CA 371. The FSD/DA should be advised of any changes (e.g., discontinuance from AFDC, new Medi-Cal case).

An unmarried/absent parent may apply for Medi-Cal and medical support services for the caretaker parent at the hospital if the caretaker parent is unable to fill out an application. Under Title 22, CCR, Section 50143, if a person is unable to file an application for Medi-Cal, "(2) a person who knows of the applicant's need to apply" may file the application. An unmarried/absent person would qualify under this definition.

2. OBRA REFERRALS

If the caretaker parent or mother is undocumented and her children are also undocumented, no medical support referral will be made. If the caretaker parent/mother is undocumented and the children are citizens or IRCA's (Immigration Reform and Control Act), a medical support referral will be made. No undocumented children will be referred.

If the caretaker parent has both OBRA children and citizen children and requests that both be referred for medical support enforcement, the county will only make a referral on the citizen children. Medical support enforcement referrals will not be made on the OBRA children. There are no referrals on OBRA children because they receive restricted benefits and the absent parent may not be a citizen or in the United States.

3. CONTINUING ELIGIBILITY

Under this program, infants born to Medi-Cal eligible women are automatically "deemed eligible" for one year, provided they continue to live with their mother and the mother remains eligible for Medi-Cal, or would remain eligible if she were still pregnant. There is no parental allocation from the father to the infant during the period of Continued Eligibility; only the mother's income, before any increases, will be allocated to the infant. However, for purposes of medical support enforcement, the father/absent parent still has a legal responsibility for the health and welfare of his children and, at the end of the 60-day postpartum period, a medical support referral must be made.

4. FOSTER CARE CHILDREN

Medical support enforcement referrals will not be done by the county Medi-Cal Eligibility Worker on foster care children. The AFDC or Foster Care Intake Workers will make child support referrals, including medical support for all foster care children. Foster care children are automatically eligible for Medi-Cal after utilizing whatever other health coverage is available. This is clarified in Section 903 of the Welfare & Institutions Code, Liability for Costs of Support. This section prohibits any imposition of medical costs upon the natural parent(s) until the county has first exhausted any eligibility the child may have under private insurance coverage, standard or medically indigent Medi-Cal coverage, and the Robert W. Crown California Children's Services Act. If there are any costs over and above 100 percent of the average Medi-Cal payment that are not covered under any of the coverages listed, the county may choose to impose those costs.

The Medi-Cal program automatically grants a Medi-Cal card to children in foster care, and providers are instructed to bill the Medi-Cal program first. Medi-Cal will pay the provider of service. Then Medi-Cal will seek repayment from the other health coverage.

5. ADULT CHILDREN

Adult children under Medi-Cal are persons 14 to 18 years of age who are not living in the home of a parent or caretaker relative and who do not have a parent, caretaker relative or legal guardian handling any of their financial affairs (Title 22, CCR, Sec. 50014). Also, the parents do not claim the child as a dependent in order to receive a tax credit or deduction for state or federal income tax purposes. Adult children **WILL** be referred for medical support enforcement. (W&I Code, Sec. 14124.93)

Disabled Adult Children under the Pickle program are at least 18 years of age or older. They will not be referred for medical support enforcement. Referrals are for those under 18.

6. TRANSITIONAL MEDI-CAL

No transitional Medi-Cal cases are to be referred. This includes children in aid codes 39, 54, and 59. These families were initially on AFDC and lost their cash grant due to increased earnings, increased hours of employment, or increased allocation of child/spousal support payments. Transitional Medi-Cal is provided to these families as an aid in helping them become self-sufficient. If they apply for Medi-Cal Only at the end of their transition period, they should be treated as a new case and a referral should be made.

7. DECEASED ABSENT PARENT

No medical support enforcement referral will be initiated for deceased absent parents. However, sufficient substantiation of the fact that the absent parent is deceased is required.

EXAMPLES:

1. Woman with three children declares father is deceased and provides birth certificate for children, death certificate for father, and marriage certificate.

   a. Marriage occurred after birth of children and father's name is not on birth certificates. **Question:** Do we do paternity referral? **Response:** Yes. Children born out of wedlock.

   b. Marriage occurred after birth of children and father's name is on birth certificates. **Question:** Do we do paternity referral? **Response:** No. If mother declares he is rightful father and that is why he is on birth certificates.

   c. Marriage occurred before birth of all children and father's name is not on birth certificates. **Question:** Do we do paternity referral? **Response:** No. Children were not born out of wedlock. Presumption is deceased person is father.

   d. Marriage occurred before birth of children and father's name is on birth certificate. **Question:** Do we refer since we have a death certificate? Must the FSD/DA validate the death for us? **Response:** No referral when there is no absent parent. He is not absent; he's deceased.

   e. Same as Number d, but woman claims that at least one of the children has a father other than the man named on the death certificate. **Question:** Would a referral be sent on this new man even though we have a death certificate on the father? **Response:** Refer if there is no name on birth certificate, but use your best judgment since children were not born out of wedlock.

2. Woman with one child applies and is granted benefits. Prior to completing the approval action, she calls the EW and advises that she has moved to County A. EW completes the disposition and processes for an intercounty transfer (ICT) to County A. **Question:** Case should be referred for medical support if she had stayed in County B, but since she is in County A physically, are we required to send the medical support referral to County B FSD/DA as part of the regulations even knowing that they will be closing because of the change in county address? **Response:** In this case, make sure County A is aware of need for medical support referral in County A in the ICT documents. Since case will be in County A, County A must make the referral.

3. Woman with two children applies and is granted benefits for one month only. Case requires cooperation with medical support. **Question:** At point that benefits are approved and cooperation with medical support referral is okay, do we send the medical support referral to the FSD/DA knowing that the case is closed and that they will do nothing with it. Seems to be a workload that is unnecessary. **Response:** If woman requests child and medical support, then refer. If a woman requests medical support enforcement and is willing to request child support enforcement services also, she may be referred to FSD/DA. If woman wants medical support enforcement services only, she can only receive this service if she is continuing on Medi-Cal. However, since there is no retro enforcement, do not refer unless she specifically wants medical support and child support enforcement services.

23E. GOOD CAUSE FOR NONCOOPERATION

The applicant or beneficiary may claim good cause for noncooperation in establishing paternity, medical support payments, or identifying third party liability if he/she feels there is a risk of emotional or physical harm to himself/herself or a child(ren) if a referral is made for medical support enforcement. The county must determine, based on criteria stipulated in CCR, Title 22, Section 50771.5, if the applicant or beneficiary, in fact, has good cause for failure to cooperate with medical support requirements. (No provision exists for a finding of good cause when the applicant or beneficiary refuses to assign to the State his/her rights to medical support, payments, care, and services.) If the county determines that good cause does not exist (Form CA 51; CCR, Title 22, Section 50101), then the applicant or beneficiary should be given an opportunity to withdraw the application, close the case, or be designated as an ineligible member of the Medi-Cal Family Budget Unit (MFBU) (CCR, Title 22, Sections 50155, 50379).

If good cause is claimed, Medi-Cal is granted pending the good cause determination if the applicants are otherwise eligible. Once good cause is established, it continues unless the mother/caretaker parent rescinds the claim for good cause and is able to cooperate with medical support enforcement. Review at redetermination to determine if circumstances have changed. It is not necessary to process another claim for good cause.

The CA 51 Good Cause Claim for Noncooperation form calls for statistical reporting. The Office of Child Support has informed us that no statistical reporting will be required of counties for good cause determinations.

1. NONCOOPERATION

When a caretaker parent has refused to cooperate and does not claim good cause, the county should refer the child(ren) for medical support services. Medical support enforcement is a condition of eligibility for Medi-Cal. No one has to make a good cause claim if he/she does not want to cooperate with medical support. It should be noted on the CA 371 that the parent will not cooperate.

The caretaker parent has the right to refuse to cooperate in medical support enforcement for himself/herself and for the child(ren). If this occurs, the caretaker parent is denied or discontinued from Medi-Cal, but the child(ren) may be granted Medi-Cal or continues receiving Medi-Cal, if otherwise eligible, and the caretaker parent does not withdraw the child(ren)'s application. The county would refer the child(ren) for medical support services. Assignment of rights is an automatic process of Medi-Cal eligibility. (Welfare & Inst. Code, Sec. 14008.6.) The caretaker parent can withdraw the application or close the case if he/she does not want a medical support referral on the child(ren). Also, in good cause denials, the county may direct the District Attorney to continue medical support enforcement without the cooperation of the caretaker parent. (Title 22, CCR, Section 50101(b)(3) and 50157(f)(12)(C).

- o If an applicant/recipient applies for Medi-Cal and does not want to cooperate in medical support, the county must deny/discontinue the applicant/recipient. Medical support is a condition of eligibility;
- o If the applicant/recipient applies for Medi-Cal and agrees to cooperate, and the referral is made, but he/she does not cooperate with the FSD/DA, discontinue Medi-Cal; and
- o If the applicant/recipient comes back two months later and agrees to cooperate, do not reinstate applicant/recipient back on Medi-Cal until he/she cooperates with the FSD/DA and

brings back a letter of cooperation. Later, if he/she comes in and wants to cooperate and makes an appointment with the DA's office and the appointment is not until the following month, the applicant/recipient will receive retroactive Medi-Cal for the month in which he/she first made the appointment if it is documented by the DA in the letter of cooperation.

2. **NOTICES OF ACTION**

Good cause in medical support is the process by which someone can make a claim that he/she has good cause for not cooperating in medical support enforcement. The claim is documented by filing a CA 51. The NOAs for good cause are to be used to inform the caretaker parent whether his/her claim has been approved or denied. An applicant may claim good cause if he/she feels that there is a risk of emotional or physical harm to himself/herself or a child(ren) if a referral is made for medical support enforcement. The county will request documentation from the caretaker parent to support the claim of good cause. This information will be sent to the FSD/DA with the CA 51, and the FSD/DA will investigate further and make a recommendation on the claim. The claim is then returned to the county for a final recommendation of approval or denial of good cause. The applicant is informed of this decision through the NOAs for Good Cause.

(For Notices of Action for Approval or Denial of Good Cause Claims, see Section 23H.)

23G. HEALTH INSURANCE ASSIGNMENTS, COST SHARING AND MEDI-CAL COPAYMENTS

As a condition of eligibility for Medi-Cal, a beneficiary must assign to the State his or her rights, and the rights of any other Medi-Cal eligible for whom he or she can legally make an assignment, to medical support, health insurance payments, or other third party payments for medical care. This assignment is completed automatically as part of the application process.

The Medi-Cal beneficiary must cooperate with the county and DHS in obtaining medical support or payments, and cooperate in identifying and providing information to assist medical providers and the State in pursuing third parties who may be liable to pay for medical care and services. Identification of a Medi-Cal beneficiary's other health coverage enables the state to cost avoid medical services and/or to recover from insurance funds previously paid to a provider.

1. HEALTH INSURANCE COST-SHARING

In addition to Medi-Cal, a Medi-Cal beneficiary may also have private health insurance. The private health insurance plan may require a deductible, copayment and/or coinsurance amount.

Following are definitions of deductibles, copayments, and coinsurance:

Deductibles

A deductible is the expense that must be incurred by an insured or otherwise covered individual before an insurer will assume any liability for all or part of the remaining cost of covered services. Deductibles are generally fixed dollar amounts and are usually tied to some reference period over which they may be incurred, e.g., $100 per calendar year, benefit period, or spell of illness.

Copayments

A copayment is a type of cost sharing whereby an insured or covered person pays a specified flat amount per service (e.g., $5 per prescription; $10 per office visit). Copayment is incurred at the time the service is received.

Coinsurance

Coinsurance is a cost-sharing requirement under a health insurance policy which provides that the insured will assume a percentage of the costs of covered services. The policy provides that the insurer will reimburse a specified percentage (usually 80%) of all or certain services above any deductible. The percent paid may be applied only to a "reasonable" charge. The insured is then liable for the remaining percentage of covered costs and may be liable for charges above those deemed reasonable, until the maximum amount stipulated under the insurance policy is reached.

2. **LIABILITY FOR INSURANCE COST SHARING**

A provider may not require the beneficiary to pay insurance copayments, deductibles, coinsurance or charges above those deemed reasonable if the provider takes the Beneficiary Identification Card (BIC) and uses it to obtain proof of eligibility through the Automated Eligibility Verification System (AEVS) or bills Medi-Cal.

Under Federal law (42 U.S.C. Sec. 1396A(25)) health insurance belonging to a Medi-Cal recipient in a child or medical support enforcement case is used as follows:

The provider of service will bill MEDI-CAL. MEDI-CAL will pay the provider of service. Then MEDI-CAL will seek repayment from the other health coverage. The recipient will not be liable for any insurance cost-sharing amount (coinsurance or deductible) unless a MEDI-CAL share of cost must be met. If the other health insurance is a Prepaid Health Plan (PHP) or a Health Maintenance Organization (HMO), the recipient must use the plan facilities for regular medical care. Out of area services or emergency care should also be billed to the PHP/HMO.

In instances where the other health coverage is an HMO, the provider may not seek reimbursement nor attempt to obtain payment for the cost of those covered health care services from the Medi-Cal eligible which are included in the Medi-Cal program's scope of benefits. Medical support beneficiaries are not liable for any copayments or deductibles. (CCR, Title 22, Sec. 51002(a); W&I Code Sec. 14019.4.)

23I. OTHER HEALTH COVERAGE OBTAINED THROUGH MEDICAL SUPPORT ENFORCEMENT

This section provides an overview of the Family Support Division/District Attorney's (FSD/DA) offices in the processing of the Medical Insurance Form DHS 6110. Item 1-e, Transmittal Letter, and Item 2, County Welfare Department Action, and Item 3-a, Notification, however, describe the county welfare department's role in this process.

1. FSD/DA REPORTING HEALTH INSURANCE COVERAGE

a. Reporting

The availability of health insurance in Medi-Cal eligible family support cases must be reported to DHS' Third Party Liability Branch, Health Insurance Section. The method used by the FSD/DAs to report the availability of health insurance is the Medical Insurance Form DHS 6110. As part of any court order and family support determination, the parents, employer of the absent parent, other third party providing health insurance to the absent parent, or FSD/DA's office will complete a DHS 6110. The DHS 6110 identifies the availability of medical insurance coverage for the dependent child(ren) on public assistance or for whom Medi-Cal is being sought.

b. Procedures

The FSD/DA will:

1. Secure a completed DHS 6110 for any action against the absent parent in a public assistance case or enforcement proceeding;

2. Ensure the DHS 6110 form is properly completed; and

3. Forward the completed form to DHS for processing.

c. Monitoring, Verifying and Enforcing

The FSD/DA will establish a monitoring system that will ensure that the DHS 6110 forms are completed and returned from the parents, employers, or other third parties who are requested to provide the health insurance information. In addition, verifying the health insurance information will ensure that all dependent children reported to DHS are eligible for coverage under the absent parent's health plan. This information is then used to cost avoid the health insurance benefits or collect from insurance carriers medical payments made by the Medi-Cal program. The FSD/DA must take appropriate action to ensure the responsible parent's obligation to obtain or maintain health insurance for the child(ren) is upheld.

d. **Notifying Custodial Parents**

The FSD/DA, in all child support and medical support cases, is required to provide the custodial parent with the absent parent's health insurance information.

e. **Transmittal Letter**

After DHS uses the health insurance information provided on the DHS 6110 form to update HIS and MEDS, a transmittal letter and the form is sent to the appropriate county welfare department for inclusion in the beneficiary's case file.

2. **COUNTY WELFARE DEPARTMENT ACTION**

When the DHS 6110 and transmittal letter are received from DHS, each county welfare department will take the following actions:

a. Place the Medical Insurance Form (DHS 6110) in the beneficiary's case file.

b. Change the OHC designator in the case file to correspond with the OHC indicator code on MEDS. There is no need to update MEDS because DHS assumes responsibility for updating MEDS in all medical support cases.

c. If the custodial parent of the beneficiary contacts the county to question the health insurance coverage for the dependent child(ren) specified on the Automated Eligibility Verification System (AEVS), explain that the coverage is being provided by the absent parent under court order for child support, and instruct the beneficiary to use the insurance coverage before using Medi-Cal if it is an HMO. If not an HMO, instruct the beneficiary to use the Beneficiary Identification Card (BIC), and Medi-Cal will bill the other health coverage.

3. **LAPSES IN HEALTH COVERAGE**

a. **Notification**

The FSD/DA requests employers of absent parents, county welfare departments, and/or other groups offering health insurance coverage to notify the FSD/DA if there has been a lapse in insurance coverage. In turn, the FSD/DA will notify DHS when it is learned that there is a lapse or change in absent parent health insurance coverage.

b. **Enforcement**

The FSD/DA will take appropriate action, civil or criminal, to enforce the obligation to obtain health insurance when there has been a lapse in insurance coverage or failure by the responsible parent to obtain insurance as ordered by the court.

4. UTILIZATION OF HEALTH COVERAGE

a. Pay and Chase

Under Federal Law (42 U.S.C. Section 1396a(25)) health insurance belonging to a Medi-Cal beneficiary in a child or medical support enforcement case is used by the following method, also referred to as "pay and chase":

The provider of service will bill Medi-Cal. Medi-Cal will pay the provider of service. Thereafter, Medi-Cal will seek reimbursement from the other health coverage.

b. Cost Avoidance

When the other health insurance is a Prepaid Health Plan (PHP) or a Health Maintenance Organization (HMO), however, the dependent must utilize the plan's facilities for regular medical care. Out of area services or emergency care for such dependents are billed to the PHP/HMO.

5. DISTRICT ATTORNEY HEALTH INSURANCE INCENTIVE

a. Policy

Effective October 1, 1993, the California Department of Social Services (CDSS) began paying the FSD/DA's an incentive of $50 for reporting health insurance coverage obtained as a result of enforcement activities for dependent children. Health insurance includes any third party insurance policy that provides coverage or benefits payable for:

Scope Code	Service Type	Services Covered
O	Outpatient	Hospital outpatient (e.g., lab work or physical therapy)
I	Inpatient	Hospital stays
M	Medical	Medical doctor visits
P	Prescriptions	Prescription drugs
L	Long term care	Long term care (e.g., nursing home) or coverage for a specific illness (e.g., cancer)
D	Dental	Dental coverage
V	Vision	Vision care

(**NOTE**: Health insurance does not include insurance coverage for automobile insurance, indemnity policies or periodic benefits for disability, hospitalization or income protection, coverage limited to a

specific circumstance (e.g., accidental injury or dismemberment), Medicare, or Medi-Cal capitated health care plans and initiatives. For a more comprehensive list, please refer to the Medi-Cal Eligibility Manual, Section 50763.)

b. **Reporting Process**

DHS will use the obtained health insurance coverage information reported by the FSD/DA on the Medical Insurance Form (DHS 6110) and provide CDSS with a quarterly county-by-county listing of the number of health insurance carriers which have been added to their computer system. The county-by-county list will be used by CDSS to pay health insurance incentives to the FSD/DAs for the health insurance carrier information reported to DHS and provided to AFDC, FC, and MNO custodial parents.

CDSS will pay these incentives to FSD/DAs on a quarterly basis. If the health insurance coverage information provided by the FSD/DA was previously known by DHS, the duplicate health insurance carrier information will not be counted, and the DHS 6110 form will be destroyed by DHS.

DHS will, however, return to the initiating county the DHS 6110 forms that are rejected because they cannot be entered into the Health Insurance System (HIS). The rejected documents will be returned weekly with a cover letter explaining the rejection reason. (See Section 23J-15 for a copy of the rejection letter.)

The causes for rejection include:

- No MEDS record found: Eligibility has not, as yet, been established on MEDS. The county welfare department must establish Medi-Cal eligibility before re-submission of the DHS 6110.
- Medi-Cal eligibility not established: The record was found on MEDS, but not eligible for Medi-Cal. Re-submit the DHS 6110 only after the county welfare department has determined the case to be eligible for Medi-Cal.
- Incomplete/Illegible form: The DHS 6110 was incomplete or illegible. Re-submit the DHS 6110 after completing or rewriting the items highlighted on the form.
- Other: Non-Codeable Insurance: Insurance could not be coded into the DHS HIS for other reasons (i.e., out of country carrier, initial report of an HMO with a termination date prior to submission, life insurance, etc.)

For additional information on DA Health Insurance Incentives, see FSD/DA Letter No. 93-24 (November 5, 1993.)