

DEPARTMENT OF HEALTH SERVICES

714/744 P STREET
SACRAMENTO, CA 95814

January 16, 1987

TO: All County Welfare Directors
All County Administrative Officers

Letter No.: 87-5

SUBJECT: IMPLEMENTATION OF COBRA PROVISIONS WHICH RESTORE AND
CONTINUE MEDI-CAL ELIGIBILITY FOR CERTAIN DISABLED
WIDOW(ER)S

Refer to: All County Welfare Directors Letter (ACWDL) No. 86-54

This letter provides instructions County Welfare Departments (CWD)s must follow to preserve Medi-Cal status for certain disabled widow(er)s who lost SSI benefits because of 1983 changes which increased their Title II widow(er)s benefits.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) established criteria to be used in restoring and continuing Medi-Cal eligibility for disabled widow(er)s if the Title II increases of 1983 resulted in a loss of their eligibility for SSI benefits and consequently, loss of their categorical Medi-Cal eligibility.

Computer tapes were sent to the Department of Health Services (DHS) from the Health Care Financing Administration (HCFA) and the Social Security Administration (SSA) which identified potential COBRA eligibles. A copy of this list was sent with ACWDL 86-54 to Medi-Cal Liaisons. We have attached an updated list (Attachment 1) which includes the figures you will need to complete eligibility determinations for these COBRA widow(er)s. According to the information currently available to DHS from HCFA and SSA, this list is inclusive of all potentially eligible COBRA individuals in California. NOTE: Some of the individuals have not responded to the original Notice of Action (NOA) sent by DHS in October, 1986. These individuals have until June 30, 1987 to respond to the NOA to maintain their eligibility for COBRA benefits. Thus far, only 18 individuals have applied for and are in receipt of COBRA benefits. As indicated in ACWDL 86-54, DHS established eligibility under COBRA for the initial 18 individuals who responded to the October, 1986 NOA. Eligibility was established three months retroactively from the date DHS received the NOA, but no earlier than July 1, 1986. A small number of individuals (3) have responded since November, 1986. These applications will be forwarded along with this letter to

the appropriate CWD for processing. The existing three months retroactive eligibility provisions apply to these and all future applicants. All additional applicant responses received by DHS will also be forwarded to the appropriate CWD.

Individuals whose eligibility was established by DHS were sent adequate and timely notice (Attachment 2) indicating that they must contact their CWD by January 31, 1987 if they wish to continue receiving eligibility under the COBRA provisions.

The COBRA Act requires that SSI criteria be used in establishing eligibility for COBRA widow(er)s and also that a reduction factor for a disregard amount and subsequent COLAs (1984-86) must be deducted from their current Title II amount similar to Pickle determinations. We are therefore requesting that you compute the eligibility determinations of COBRA eligibles using existing Pickle procedures, unless changes are noted below. An example of computing the Title II disregard amounts for the COBRA widow(er)s is attached (Attachment 3).

Following are instructions for completing eligibility determinations for COBRA widow(er)s.

Application Process

- I. Use Pickle application (DHS 7038).
 - A. Follow existing procedures, except where noted below:
 1. Return of application
 - a. If individuals are currently receiving COBRA Medi-Cal cards they must contact the CWD and request an application by January 31, 1987. If they do not return the application or contact the CWD within 30 days of receipt of the application, the application should be denied.
 - b. If individuals are not currently receiving COBRA Medi-Cal cards they must contact the CWD or DHS by 6/30/87. If they do not contact either the CWD or DHS, they will not be entitled to receive zero share-of-cost cards under the COBRA provision.
- II. Personal contacts
 - A. Follow existing regulations contained in Title 22, CAC, Section 50163 (a) (3) (A)-(D) and 50165, and the existing Pickle procedures.

III. County of Responsibility

- A. Follow existing Pickle procedures. Attachment 4 contains a list of COBRA county contacts. If your CWD has been identified as having COBRA applicants, and you have not yet designated a COBRA contact person, you must contact DHS by January 30, 1987.

IV. Application Processing

- A. Follow existing Pickle procedures.
 - 1. If individuals are currently receiving COBRA Medi-Cal cards, you should determine eligibility from the date that they apply at the CWD.
 - 2. If individuals are not currently receiving COBRA Medi-Cal cards, initial eligibility should be determined 3 months retroactively from the date that they apply at the CWD. Applicants may only apply for COBRA benefits at the CWD until June 30, 1987.
- B. Eligibility is to be redetermined annually from the date that they applied for COBRA benefits.

V. Statistical Reporting

- A. DHS anticipates requests from HCFA regarding number of eligibles. Due to the small number of COBRA individuals in California, it should be relatively simple to maintain a master list of individuals. Each county should maintain a master list to monitor the application process of all COBRA individuals in their county. This list must reflect the name, address and telephone number of each applicant, the date an application was mailed, and the date the completed application was received by the CWD. A printout has been attached (Attachment 1) to facilitate your record keeping. This list has been sorted by county of residence at the time of the first NOA sent by DHS (10/86), and sorted alphabetically within each county.

VI. Retroactive Claiming

- A. There is no mechanism in the COBRA procedures for retroactive claiming of benefits. COBRA beneficiaries are only entitled to 3 months retroactive zero share-of-cost Medi-Cal cards. These cards are to be sent with Attachments 5 and 6 (letters to the beneficiary and provider) which explains the instructions for claiming retroactive reimbursement of paid claims.

V. Aid Code

- A. All COBRA beneficiaries are to be assigned an aid code of 36. The procedures manual will be revised to reflect

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expansion of this aid code. DHS has assigned aid code 36 to the initial 18 individuals whose eligibility has been established prior to November, 1986.

Thank you for your cooperation in complying with requirements and short deadlines in these procedures. Any questions should be directed to Michele White (916) 445-1912 or ATSS 8-485-1912.

Sincerely,

Original signed by

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Attachments

Attachment 1 sent to Medi-Cal Liaisons only

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Expiration Date: July 1, 1987

Legend for attachment of potential COBRA beneficiaries

County Code: Self explanatory

Beneficiary Name

Payee Information

Address: Address verified by SSA and beneficiary; phone number, when provided, verified by beneficiary

Beneficiary/Claim

Account No.: Medi-Cal number provided, if available; SSN provided by SSA- NOTE: beneficiary may be claiming on SSN of spouse, therefore SSN provided may not be beneficiary's.

Date of

Termination: Date provided by SSA and is to be used to compute COLA disregard from Pickle Disregard Computation Worksheet (DHS 7029-11/86)

Gross Amount
of Title II

1/84: Amount provided by SSA

Current Gross
Amount of

Title II: Current gross amount, as reported by HCFA, as of 7/1/86

Disregard
Amount of

Title II: Mathematical computation- Current gross amount of Title II minus Gross amount of Title II 1/84 equals Disregard amount of Title II. This disregard amount will stay the same from year to year.

Notice Preparation Date: _____

Beneficiary ID Number: _____

Our records indicate that you may be eligible for continued zero share of cost Medi-Cal under the 1985 Consolidated Omnibus Budget Reconciliation Act (COBRA) as it relates to your Social Security benefits. This notice is important. PLEASE READ IT CAREFULLY!

If you are one of the persons covered by the COBRA Act, you will be eligible for continued Medi-Cal coverage without a share of cost. To be eligible you must contact your local County Welfare Department at the following address. If you do not contact your local County Welfare Department by January 30, 1987 the benefits that you are receiving now under the COBRA Act will stop as of January 31, 1987.

After you contact the county, they will set up an appointment for you to come in for an interview with a county worker. This interview and the completion of the forms they will provide, are necessary to establish your ongoing Medi-Cal eligibility under the COBRA Act.

If you do not participate in the interview and return the forms, your Medi-Cal eligibility cannot be determined and your Medi-Cal benefits under the COBRA Act will end. Even though you may no longer be eligible for Medi-Cal under the COBRA Act, you may still be eligible for Medi-Cal benefits under another Medi-Cal category, but there may be a break in your coverage. If you are interested in receiving continuing coverage under the COBRA Act, you should contact your local county welfare department immediately.

Keep this letter to show to the county welfare department. It will help them to determine your Medi-Cal status.

If you need assistance, or have questions, you should check your Social Security records, call your local Social Security Office, or contact your local county welfare department.

Instructions for Computing Title II Disregard Amounts for COBRA Individuals

Title II disregard amounts are to be computed using Pickle instructions and worksheets: Disregard Computation Worksheet (DHS 7029-11/86) and Financial Eligibility Worksheet (DHS 7021-1/85). Changes in procedures, if any, will be noted below.

Disregard Computation Worksheet- No changes.

Financial Eligibility Worksheet- Part 1., line 2., - write in the amount of the COBRA disregard provided and write in the amount of Title II disregard amount computed on the Disregard Computation Worksheet. Add these two numbers together and the total will be the Title II COLA disregard amount to be used on this line and on line 2., Part V. The remainder of the form has no changes.

Example:

COBRA disregard amount provided by SSA: \$150.00

Pickle Disregard Computation Worksheet:

1. Potential COBRA person's current RSDI Benefit Amount:		450.00
2. Date last SSI/SSP check rec'd: 4/15/84	X multiplier	.0749
3. Total disregard amount rounded to nearest dollar		<u>\$ 34.00</u>

Pickle Financial Eligibility Worksheet:

Part I.

1. Total earned/unearned income (from MC 176 M, Part 1, Line 14) \$430.00

Part VI. Pickle Eligibility Calculation

1. Current SSI/SSP payment level for individual	\$560.00
2. Total Countable income	\$246.00

If line VI-2 is less than VI-1, the applicant is Pickle/COBRA eligible

1967 Last SSI/SSP Check Received	Multiplier
Between 1/86 and 12/86	0.0128
1/85 and 12/85	0.0425
1/84 and 12/84	0.0749
1/82 and 12/83	0.1062
7/81 and 6/82	0.1678
7/80 and 6/81	0.2516
7/79 and 6/80	0.3452
7/78 and 6/79	0.4042
7/77 and 6/78	0.4406
4/77 and 6/77	0.4717

DISREGARD COMPUTATION WORKSHEET
(PICKLE ELIGIBLE OR COUPLE AND/OR
INELIGIBLE SPOUSE WITH
RSDI INCOME)

Date _____
Case Name _____
Case No. _____
EW No. _____

A. POTENTIAL PICKLE PERSON'S NAME

1. Current RSDI Benefit Amount \$ 450
2. Date last SSI/SSP check received 4/15/84 X .0749
(Multiplier)
3. Total Amount \$ 33.71

(Round to nearest \$) **DISREGARD AMOUNT**
\$ 34.00

B. POTENTIAL PICKLE PERSON'S NAME

(Use if BOTH spouses pass the Screening Test)

1. Current RSDI Benefit Amount \$ _____
2. Date last SSI/SSP check received _____ X _____
(Multiplier)
3. Total Amount \$ _____

(Round to nearest \$) **DISREGARD AMOUNT**
\$ _____

C. SPOUSE OF POTENTIAL PICKLE PERSON

(Use if one spouse has passed the Screening Test and one has not, but both have RSDI income.)

1. Current RSDI Benefit Amount \$ _____
2. Date spouse's SSI/SSP was discontinued _____
OR
Date when this person started receiving RSDI _____
(WHICHEVER IS LATER)

3. Total Amount _____ X _____
(Multiplier)
\$ _____

(Round to nearest \$) **DISREGARD AMOUNT**
\$ _____

FINANCIAL ELIGIBILITY WORK SHEET
(Individual or Couple, or Applicant With an Ineligible Spouse)

Case Name: Case Number:

Applicant's Name:

PART I. 1. Applicant's total earned and unearned income (MC 176 M, Part I, Line 14) 430
2. Title II COLA disregard amount 184
3. Total countable income (subtract 1-2 from 1-1) 246

150 + 34 =

Handwritten calculations: 430, 184, 246

PART II. INELIGIBLE SPOUSE'S UNEARNED INCOME

1. Ineligible spouse's total unearned income--do not include public assistance income
2. Title II COLA disregard amount
3. Countable unearned income (subtract II-2 from II-1)
4. Allocation for ineligible children. (If no children, enter zero in II-4c)
Do not include Pickle eligible children

Table with 5 columns: Child No. 1, Child No. 2, Child No. 3, Child No. 4, Child No. 5. Rows include Allocation (couple FBR minus individual FBR), Subtract child's income, and Total allocation.

5. Remaining unearned income (subtract II-4c from II-3)

PART III. INELIGIBLE SPOUSE'S EARNED INCOME

1. Ineligible spouse's gross earned income
2. Unused portion of allocation for ineligible child(ren)
3. Remaining earned income (subtract III-2 from III-1)

PART IV. INELIGIBLE SPOUSE'S TOTAL INCOME AFTER ALLOCATIONS (Add II-5 and III-3). (If less than the difference between the FBR for a couple and the FBR for an individual, deeming not applicable. Make no entry for ineligible spouse's income in Part V.)

PART V. COMBINED INCOMES (eligible individual or couple and/or ineligible spouse after ineligible child allocations).

1. Applicant's unearned income 450
2. Applicant's Title II COLA disregard amount - 184
3. Applicant's countable unearned income (subtract line V-2 from line V-1) 266
4. Ineligible spouse's unearned income (line II-5) +
5. Combined unearned income (add lines V-3 and V-4)
6. Subtract general income exclusion -20
7. Combined countable unearned income 246
8. Earned income of applicant and spouse (use amount from line III-3 for ineligible spouse) +
9. Subtract balance of general exclusion not offset by unearned income (line V-6)
10. Remaining earned income
11. Subtract work expense exclusion -65
12. Remaining earned income
13. Subtract 1/2 remaining earned income
14. Countable earned income
15. Total countable income (add lines V-7 and V-14)

Handwritten calculations: 450, 184, 266, 246, 20, 246

PART VI. PICKLE ELIGIBILITY CALCULATION

1. Current SSI/SSP payment level for an individual or a couple
2. Enter total countable income (line V-15) 560
If line VI-2 is less than VI-1, the applicant is Pickle eligible.

Handwritten calculation: 560, 246

Eligibility Worker Signature, Worker Number, Computation Date, County Use

Person #1 _____

PICKLE APPLICANT'S TOTAL COUNTABLE INCOME

A. NONEXEMPT UNEARNED INCOME	
	a. ABD-MN 450
1. OASDI	
2. Net Income from Property	
3. Other—Itemize	
4.	
5. Total (add 1 thru 4)	
6. Combined unearned income	450
7. Any Income deduction	-S20 20
8. Countable unearned income (6 minus 7)	430
B. NONEXEMPT EARNED INCOME	
9. Gross Earned Income	a.
10. Combined earned income	
11. SE5 earned Inc. deduction plus S ____ unused S20	
12. Remainder (10 minus 11)	
13. Countable earned income (divide 12 by 2)	
14. Total countable income (add 8 and 13)	430

NOTE:
If any of the following deductions apply, complete MC 176W, Part VI before completing Column 1:

Educational Expenses	Section 50547
Absent Parent Support	Section 50541
Student Deduction	Section 50551
S30 plus 1/3	Section 50551.1
Work Expenses for the Blind	Section 50551.4
Income for Self-Support	Section 50551.5

NEEDS TEST/COUNTABLE INCOME

1. Total Income \$ (line 14, above)	430
2. Title II COLA Disregard amount	184
3. Total Countable Income (subtract line 2 from line 1)	246
*4. SSI/SSP Payment Level for 1	560

*IF LINE 3 EXCEEDS LINE 4, THIS PERSON IS NOT PICKLE ELIGIBLE.

EW Signature/EW #	Date
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County Medi-Cal COBRA Contacts

Alameda County

Velora Savage
Alameda Co. Social Services Agency
24041 Amador Street
Hayward, CA 94544
415-881-6201

Butte County

Shirley Flowers
Butte Co. Dept of Social Welfare
42 County Center Drive
Oroville, CA 95965
916-534-4286

Contra Costa County

Pamela Morgan
Contra Costa Co. Social Services Dept.
3630 San Pablo Dam Rd
El Sobrante, CA 94803
415-231-3617

Barbara J. Smith

Contra Costa Co. Social Services Dept.
3865 Shopping Heights Lane
Pittsburg, CA 94565
415-439-4290

Los Angeles County

David Corbin
L.A. County Dept. of Public Social Services
P.O. Box 5493
El Monte, CA 91731
818-572-5664

Napa County

Toni Holland
Napa Co. Dept. of Social Services
P.O. Box 329
Napa, CA 94559
707-253-4526

(continued)

Orange County

Wilma Lee
Orange Co. Social Services Agency
1624 W. 19th Street
P.O. Box 1999
Santa Ana, CA 92702-1999
714-834-8275

San Diego County

Teresa Shirley
San Diego Co. Dept. of Social Services
620 E. Valley Parkway
Escondido, CA 92026
619-741-4475

San Francisco County

Michael Fitzpatrick
San Francisco Co. Dept. of Social Services
P.O. Box 7988
San Francisco, CA 94120
415-557-5840

Santa Clara County

Robin Bryant
Santa Clara Co. Dept. of Social Services
55 West Younger
San Jose, CA 95110
408-299-2188

Tulare County

Fern Haller
Tulare Co. Welfare Dept.
P.O. Box 671
Visalia, CA 93279
209-733-6142

Date: _____
Beneficiary Name: _____
Worker Name: _____
Worker Phone: _____

Dear _____ :

Attached is your prior-month Medi-Cal card for the month(s) of _____ . This card(s) was issued in accordance with the 1985 Consolidated Omnibus Budget Reconciliation Act (COBRA).

Also attached is a letter to your medical provider, granting permission to bill the Medi-Cal program more than two (2) months after the month of service. Please give your provider your Medi-Cal identification label for the month of service along with a copy of that letter, so that they can be attached to the completed bill.

The Medi-Cal program cannot pay your provider's bill unless your Medi-Cal label and a copy of that letter are submitted with the bill for the month of service.

If you were already on Medi-Cal and paid a share of cost to your provider, give the attached letter to your provider with your new Medi-Cal identification label for the month of service so that your provider can bill the Medi-Cal program. Your provider will reimburse you for any share of cost amount you paid to him/her after your provider receives payment from the Medi-Cal program and if the service is a Medi-Cal covered service.

If you have any questions, please call your Eligibility Worker at your County Welfare Department.

Sincerely,

County Welfare Office

Attachment

Dear Medical Provider:

Attached is a Medi-Cal identification label for _____ for the month(s) of _____. This label was issued in accordance with the 1985 Consolidated Omnibus Budget Reconciliation Act (COBRA). This law modifies the eligibility of certain Medi-Cal beneficiaries who had not previously been eligible for Medi-Cal or had previously been assigned a Share of Cost (SOC) obligation. Therefore, any SOC payments made by these beneficiaries were inappropriate and must be refunded. Services provided by you but not billed or, only partially billed, to Medi-Cal must now be submitted to the appropriate Medi-Cal intermediary for processing.

Upon presentation of the POE, you must submit a Medi-Cal claim for reimbursement subject to the rules and regulations of the Medi-Cal program. Payment received from the State in accordance with the Medi-Cal fee structure shall constitute payment in full. The provider shall return any and all payments made by the beneficiary for Medi-Cal covered services upon receipt of Medi-Cal payment. (Welfare & Institutions Code 14019.3)

Please note that the fiscal intermediary will not honor a claim submitted more than two (2) months after the month of service unless a copy of this letter is attached to the claim.

To ensure that these claims will be accepted for processing, code the billing limit box on the claim form with a billing limit exception code "1" and indicate the date proof of eligibility (POE) was received in the remarks section of the claim. In addition, a copy of this letter and the patient's Medi-Cal label must accompany the claim. You have 60 days to bill after the date POE was received. (See Medi-Cal Provider Manual, Section 2).

If the patient had paid you for services because of a SOC obligation, you must bill Medi-Cal for these services using the instructions above. You must return the money once payment is received from Medi-Cal. (Welfare & Institutions Code 14019.3)

If the patient had paid you for part of the charges as a result of the SOC obligation but, the remainder of the charge was billed to Medi-Cal, this money must be returned to the patient once payment is received from Medi-Cal. Since some payment has previously been received from Medi-Cal, it is not possible to bill using the procedure described above. In order to receive an adjustment on the previously paid claim, you must submit a Claims Inquiry Form (CIF) or a First Level appeal. You must indicate

that the original SOC deduction was incorrect and request that the claim be reprocessed using the new eligibility information. You must submit a copy of this letter with your corrected claim.

Should you have any questions regarding this matter, please contact the Department of Health Services, Provider Services Section at (916) 323-1945, or County Welfare Department,
(area code) telephone number.

Sincerely,

Medi-Cal Program Manager

cc: Provider Services Section

Eligibility Worker/Date
Expiration date: July 1, 1987