STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

GEORGE DEUKMEJIAN, *Governor*

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320

To: All County Welfare Directors
All County Administrators

June 28, 1990
Letter No. 90-66

TRANSITIONAL MEDI-CAL (TMC)

This letter is intended to clarify several areas that caused confusion during the implementation of the new TMC provisions of the federal Family Support Act of 1988 and to transmit the draft regulations for TMC, the language for the required notices, a draft of the status report (MC 176 TMC/TCC), and the language to be used for a transmittal to accompany the MC 176 TMC/TCC.

Implementation Date for TMC (Clarification)

One area that created many questions during the implementation phase concerned the effective date of the new law. Federal law restricted TMC to families who became ineligible to receive Aid to Families with Dependent Children (AFDC) on or after April 1, 1990. NOTE: This means people discontinued from AFDC March 31 (ineligible April 1). Example: A family was discontinued from AFDC for one of the qualifying reasons on March 31, 1990, that family is ineligible for AFDC on April 1 and would receive TMC.

Definition of "Caretaker Relative"

A second area of concern was in the use of the phrase "caretaker relative". The new federal law governing TMC is very specific. It requires that the Department of Health Services (DHS) use the AFDC definition of "caretaker relative". There is no flexibility allowed in the definition, and the State is specifically prohibited from using the Medi-Cal definition. For purposes of TMC only, the following definition of caretaker relative must be used:

> A caretaker relative means the person in the home responsible for the care and control of a dependent child. A caretaker relative must be one of the following:
>
> 1. The father, mother, brother, sister, half-brother, half-sister, uncle, aunt, first cousin, nephew, niece, or any such person of a preceding generation denoted by the prefixes grand, great, great-great.
>
> 2. The stepfather, stepmother, stepbrother, or stepsister.

3. The spouse of any person specified in 1 or 2 even if the marriage has been terminated by death or dissolution.

Questions and Answers

The following questions are representative of those most frequently asked. My staff will be available to answer individual county questions as well as to provide whatever assistance is necessary.

Question 1--Is there any reason that a family can be discontinued from TMC during the initial six-month period?

Answer 1--Yes, if the last child (as defined in Title 22, California Code of Regulations (CCR), Section 50030) leaves the home, the family is discontinued on the last day of the month in which that child resided in the home.

Question 2--During the additional (or second) 6-month period, how can it be determined, if the income fluctuates, whether the family exceeds the 185 percent of federal poverty level (FPL) ceiling?

Answer 2--The 185 percent test should be applied to the average of the income during the quarter for which it is reported.

Question 3--What types of income are counted?

Answer 3--The family's average gross earnings, less the amount actually paid for child care necessary for the continued employment of the caretaker relative and any health insurance premiums paid by the family members.

Question 4--Are families who are discontinued from AFDC due to collection (or an increased collection) in child/spousal support eligible for TMC?

Answer 4--No. Those families are eligible for Four Month Continuing Medi-Cal under the provision of Title 22, CCR, Section 50243. The Omnibus Budget Reconciliation Act of 1989 extended the Four Month Continuing category (Aid Code 54 only) indefinitely.

Question 5--Why do the TMC status reports have to be completed by the beneficiary and returned to the county welfare department (CWD) by the 21st day of the fourth month of the initial (or first) six-month period?

Answer 5--The federal law specifies that status reports, which cover the three preceding months, must be completed and returned to the CWD at the following times:

- 21st day of the fourth month of the initial six-month period. This report is used to determine eligibility (and share of cost, if applicable) for the additional six-month period.

- 21st day of the first month of the additional six-month period. This information is used to determine if the family's gross earnings exceed 185 percent of FPL and whether the family meets all the conditions of eligibility.

- 21st day of the fourth month of the additional six-month period. This report is used for the same purposes as the previous report.

Question 6--When may TMC be discontinued?

Answer 6--During the initial six-month period, TMC may only be discontinued at the end of the month in which the last child ceases to reside in the home, so long as a ten-day Notice of Action can be provided.

During the additional six-month period, TMC may be discontinued, with adequate notice, at the end of any month for any of the following reasons:

- The caretaker relative becomes unemployed without good cause.

- The family's gross monthly earnings exceed 185 percent of the FPL.

- There are no children living in the household.

- The family fails to meet the mandatory reporting requirements.

Question 7--An AFDC recipient is discontinued for failure to return a CA 7 and is put on Medi-Cal only (Aid Code 38). The CWD determines that the caretaker relative returned to work and the family would have been eligible for TMC if the CA 7 had been returned. Is the family eligible for TMC?

Answer 7--Families are only eligible for TMC if their AFDC is discontinued for one of the qualifying reasons. If the CWD becomes aware, within 30 days of the AFDC discontinuance, that the family could have been determined ineligible for AFDC for one of the TMC qualifying reasons, TMC should be granted retroactive to the date of AFDC ineligibility.

Question 8--Would a family be eligible for TMC if their 17-year-old son obtained full-time employment which caused the AFDC ineligibility?

Answer 8--No, unless the son was also the caretaker relative. Eligibility for TMC is restricted to those families who become ineligible for AFDC due

to an increase in earnings of the caretaker relative. NOTE: In the case of a two-parent household, the eligibility may be due to the employment of either parent. TMC is permitted if any member of the family causes AFDC ineligibility due to the loss of the time limited earned income disregards (i.e., the $30 plus one-third or $30 earned income disregards).

Question 9--Would a person who enters the family after TMC begins be considered an eligible family member?

Answer 9--No, unless the person is a newborn or a child that would have been eligible in the AFDC case in the month of discontinuance. NOTE: A person who no longer meets the definition of a child (Title 22, CCR, Section 50030) is not an eligible family member.

Question 10--What is the definition of family as it is used for TMC?

Answer 10--The members of a family unit in which the caretaker relative received AFDC in the prescribed period (three of the last six months), or who were members of the AFDC-Assistance Unit (AU) the month the family was determined to be ineligible for AFDC.

Question 11--What is considered in determining a family's monthly gross earnings?

Answer 11--Earned income of all family members living in the home who were members of the FBU during the month the family became ineligible for AFDC and any parent(s) who return to the home during the TMC period.

Question 12--How are the family's monthly gross earnings computed?

Answer 12--Monthly amounts are derived by dividing countable earnings for the three-month reporting period by three. Gross earnings are adjusted to reflect changes in the MFBU for each of the periods covered by the reports. Gross earned income is that which is not excluded in Article 10 of the Medi-Cal Eligibility Manual. Gross earned income does include income that is disregarded in Article 10. The gross earnings are then reduced by the amount of the caretaker's child care costs necessary for employment and by the amount of any health insurance premiums paid by the family members.

Question 13--When is a family considered to have "received" AFDC?

Answer 13--In any month, including zero basic grant months, in which AFDC payments are correctly paid. A family determined by the AFDC eligibility worker to have erroneously received AFDC benefits or who receives AFDC payments pending an appeal is not considered to have "received" AFDC

benefits in any month payments were erroneously paid and may be recovered. Payments made because of administrative error are not payments considered correctly "received".

Question 14--If a family fails to return a TMC status report (Enclosure 2), when is TMC terminated?

Answer 14--Do not terminate TMC during the initial six-month period if the reporting requirements are not met; instead deny benefits for the additional six-month period. During the additional period, TMC may be reinstated if the report is received within 30 days of the date it was due, and the CWD determines that the family had good cause for not returning the report on time.

Question 15--What is the procedure to follow when the TMC status report is returned timely?

Answer 15--The CWD must determine whether:

- The caretaker was employed during all of the preceding three months and, if unemployed in any one or more months, it was due to involuntary loss of employment, illness, or other good cause; and/or

- The family's reported average gross earnings for the last 3 months of the initial period or the first 3 months of the additional period exceeded 185 percent of the federal poverty level for a family of equivalent size. Use the average family size for the immediately preceding three months when there is a change in family composition during the three-month reporting period. Family size must take into account an ineligible, financially responsible relative who has earned income.

Question 16--What is the next step if the CWD determines that the family is no longer eligible to receive TMC?

Answer 16--During the additional period, immediate action must be taken to terminate, with adequate notice, the TMC benefits unless it appears that a family member is eligible under another Medi-Cal program. NOTE: This does not apply to County Medical Services Program (CMSP) eligibility. When it appears that a family member will be eligible under another program, do not terminate TMC until Medi-Cal eligibility for the entire family is determined under the other program.

Send an MC 210 or an MC 210E and other Medi-Cal forms, as necessary, and provide a specific time limit for the beneficiary to provide the required

information. If the information is not provided within the time limits established by the CWD, terminate TMC.

Question 17--What notices are CWDs to provide to persons receiving TMC?

Answer 17

- When AFDC benefits are terminated, the following information must be included on the AFDC Notice of Discontinuance:
  - A statement advising families of their right to TMC.
  - The reporting requirements for TMC.
  - An explanation of reasons why their TMC could be discontinued.
  - Verification that their Medi-Cal benefits are being continued under TMC.

NOTE: Enclosure 1 contains some suggested language that may be used to fulfill this requirement.

- During the initial six-month period, the following notices must be provided:
  - In the third month advising families of the requirement to report the family's monthly gross earnings and the caretaker's costs for necessary child care by the 21st day of the fourth month of the initial period, and advising them of their right to receive TMC during the additional period.
  - In the sixth month advising families of the requirement to report family gross earnings and the caretaker's costs for child care by the 21st day of the first and fourth months of the additional period and of the following:
    1. A statement advising whether the family has a Medi-Cal share of cost. (NOTE: Even though federal law allowed states to assess a share of cost or a partial payment of health insurance premiums during the additional six-month period, DHS has opted at this time to continue TMC for the additional six-month period at no share of cost.)
    2. A description of "out-of-pocket expenses" as they apply to child care.

3. A statement that full scope of benefits under Medi-Cal will continue during the TMC period. NOTE: Federal law permits states to allow a reduced scope of benefits during the additional six-month period. At this time DHS has opted to provide full-scope benefits.

4. The reporting requirements, including the beneficiary's ten-day responsibility to report any changes to the CWD.

5. The option to receive TMC during the additional period and the need for the family to advise the CWD if additional TMC is not desired.

- o During the additional six-month period, provide notice in the third month which includes:
  - A statement of the requirement to report the family's gross earnings and child care costs by the 21st day of the following month.
  - The amount of the family's share of cost or of any health insurance premiums that are required. At this time there is no share of cost or health insurance premium associated with TMC.
- o When TMC is terminated:
  - Provide notice of termination and advise families of their right to appeal when families become ineligible for any of the specified reasons. If TMC is discontinued in the additional period due to excess income, failure to report, or lack of earnings, the notices must explain how families may reestablish Medi-Cal eligibility.

Question 18--When families are discontinued from TMC, do they receive aid paid pending?

Answer 18--Aid paid pending is provided for children only when:

- o The child is determined ineligible under another program.
- o The basis of the appeal is the accuracy of that eligibility determination.
- o The state hearing is requested timely.

Question 19--For fiscal purposes how are CWDs to count TMC cases?

Answer 19--During the initial and additional six-month period, they will be counted as a continuing Medi-Cal case.

Question 20--When will the required forms and notices be available for ordering from the DHS Warehouse?

Answer 20--The forms and notices will not be available until July. There are no mandated forms except the TMC Status Report (Enclosure 2). We have provided suggested forms (Enclosures 1, 3, and 4) with this letter. CWDs should feel free to develop their own forms and notices so long as they comply with the requirements of Answer 17.

Question 21--If the TMC Status Report is returned later than the 21st day of the fourth month but prior to the actual discontinuance, at the end of the sixth month, is the family eligible for the additional six-month period?

Answer 21--Yes.

Question 22--Does a break in TMC benefits make a family ineligible to receive continued TMC?

Answer 22--Yes. If a family receives TMC for seven months and is discontinued, they are not eligible for the remaining five months of TMC.

Question 23--Must the Medi-Cal residency requirements be met for families receiving TMC?

Answer 23--Yes, TMC is only provided in the state the family received AFDC benefits.

Question 24--Does the child have to continue to meet deprivation in order for TMC benefits to continue?

Answer 24--No. The child only needs to meet the definition of child in Title 22, CCR, Section 50030.

Question 25--Does TMC apply to state only AFDC cases that are discontinued for one of the qualifying reasons?

Answer 25--No. Those discontinued from state-only AFDC (Aid Codes 32 and 33) are not eligible for TMC. Counties must reevaluate discontinued recipients for Medi-Cal eligibility under any other Medi-Cal program.

Question 26--CWDs are required to obtain status reports in the first and fourth months. No other reports are required. If a CWD's computer system is already set up for monthly reporting, may it continue to request monthly reports even though the law does not require reports that often?

Answer 26--Yes, but the CWD cannot discontinue TMC for failure to report except at the time the required reports are due and timely notice has been provided. In addition, for comparison of the family gross earnings to 185 percent of the FPL, it is required that such comparison be based on the family's average gross earnings during the immediately preceding three-month period.

TMC Regulations

The draft regulations (Enclosure 5) that are sent with this letter have not completed the regulation approval process. It is anticipated there will be minor changes necessitated during the review process. These changes will not impact the policies established by the draft but may alter the language and the format. This draft is being provided solely for informational purposes. As soon as these regulations are filed with the Secretary of State, CWDs will be sent a copy of the filed version.

Procedures

When the regulations are finalized, the update to the Medi-Cal Eligibility Manual Procedures Section will be prepared. Prior to that time the procedures will be released in draft form to CWDs for comment.

Training

My staff is available to conduct regional training. A schedule of the training is being prepared and will be distributed to counties when the plans are finalized. At this time, the following are the training sites and dates:

June 21 and 26--Los Angeles County only
July 10--Butte County
July 12--Mendocino County
July 18--El Dorado County
July 30--San Luis Obispo County

Additional training locations in southern and central California are being identified.

Questions and comments concerning TMC and requests for specific training locations should be directed to Kristi Allen at (916) 324-0649.

Thank you for your assistance with the ever changing and complex requirements of the Medi-Cal program.

Sincerely

ORIGINAL SIGNED BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosures

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Enclosure 1

Transmittal Letter
TMC Report

In order for your TMC to continue, you must fill out the enclosed TMC status report and return it to the county welfare department no later than _____ 21, 199_____.
(4th month) (year)

This report must tell us your gross monthly earnings, who in your family is working, the names and ages of the people living with you, and what your out-of-pocket* expenses for child care are.

* Out-of-pocket expenses mean what you actually pay for child care. It does not mean child care costs that are paid by someone other than you or costs that are reimbursed to you.

Enclosure 2

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES

TRANSITIONAL MEDI-CAL (TMC)/TRANSITIONAL CHILD CARE (TCC) STATUS REPORT (QUARTERLY)

Month 1	Month 2	Month 3

THIS STATUS REPORT IS FOR THE MONTHS OF:

RETURN THIS FORM NO LATER THAN THE 21ST DAY OF _____

IMPORTANT: COMPLETE, SIGN, AND RETURN THIS REPORT TO THE WELFARE DEPARTMENT IN THE ENCLOSED ENVELOPE. Attach proof of your income, actual child care expenses paid and total hours of employment for the three months noted above. If you have any questions regarding this form or the items to be reported, contact your eligibility worker.

- For **Transitional Medi-Cal (TMC)** - You will receive three status reports during a twelve month period. If you do not complete and return these reports, your eligibility for TMC will be discontinued.
- For **Transitional Child Care (TCC)** - You will receive only one report due in the 4th month of your TCC eligibility period. If you do not complete and return the report, you will not get TCC benefits beginning with the 7th month of the 12 month period.

TMC/TCC

PART A. DISCONTINUANCE REQUEST

I request that my ***Transitional Medi-Cal*** be stopped on the last day of _____ . (Month / Year)

I request that my ***Transitional Child Care*** be stopped on the last day of _____ . (Month / Year)

I know that I can reapply for ***Medi-Cal*** at any time.

_____ (Signature of Applicant) _____ (Date)

IF YOU WANT YOUR TMC OR TCC ELIGIBILITY TO CONTINUE, PLEASE COMPLETE AND SIGN PART B OF THIS REPORT.

TMC/TCC

PART B. ELIGIBILITY STATUS INFORMATION

Did anyone receive any income, money, or benefits during the report period? Yes ☐ No ☐
(Salary, wages, tips, commissions, bonuses, vacation pay.) If "YES" attach proof.

Who Received Income, Money, or Benefits	Type of Income, Money or Benefits (see list above)	Amount Before Deductions		
		Month 1	Month 2	Month 3
		Gross Amount: $	Gross Amount: $	Gross Amount: $
		Hours Worked:	Hours Worked:	Hours Worked:
		Dates Received:	Dates Received:	Dates Received:
		Gross Amount: $	Gross Amount: $	Gross Amount: $
		Hours Worked:	Hours Worked:	Hours Worked:
		Dates Received:	Dates Received:	Dates Received:
		Gross Amount: $	Gross Amount: $	Gross Amount: $
		Hours Worked:	Hours Worked:	Hours Worked:
		Dates Received:	Dates Received:	Dates Received:
		Gross Amount: $	Gross Amount: $	Gross Amount: $
		Hours Worked:	Hours Worked:	Hours Worked:
		Dates Received:	Dates Received:	Dates Received:

MC 176 TMC/TCC (4/90)

TMC 2. Did you or anyone pay for child care expenses which have not or will not be reimbursed ? Yes ☐ No ☐

If "YES" complete the following:

Name of Child(ren)	Age	Amount Paid for Child Care Expenses			Name of Child Care Provider
		Month 1	Month 2	Month 3	

TMC/TCC 3. Did you have changes in your family or household during the time specified? (Include change of address, change of child care provider, change of employment, anyone that moved into or out of your home, or anyone who was born or who died.) Yes ☐ No ☐

If "YES" complete the following:

Name	Relationship	What Happened	Date

TMC 4 a) Do you or anyone have or expect to receive private health insurance? (This includes health, hospitalization such as: Kaiser, Blue Cross, vision, long-term care insurance, or dental insurance paid by an employer, absent parent, or other person who is in or out of the home.) Yes ☐ No ☐

b) Do you have or expect to receive health insurance through your employer? Yes ☐ No ☐

c) Is health insurance available from your employer for a fee? Yes ☐ No ☐

If "YES" complete the following:

Name of Insurance	Person(s) Insured

CERTIFICATION

I understand that reported facts may result in benefits being changed or stopped.

I understand that the statements I have made on this form are subject to investigation and verification.

I understand that I must notify my worker within 10 days of any change.

I understand that failing to report facts or giving wrong or incomplete facts can result in legal prosecution with penalties of a fine, imprisonment or both. California law states that for Medi-Cal, if I fail to report changes in income or family status without good cause and such failure causes more than $400 to be wrongly paid out, I have committed a felony.

I understand that I must repay any TCC benefits I am not entitled to receive, even when the benefits are paid to the provider.

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE UNITED STATES AND THE STATE OF CALIFORNIA THAT THE INFORMATION CONTAINED IN THIS REPORT IS TRUE AND CORRECT AND IS COMPLETE FOR THE ENTIRE REPORT PERIOD.

Signature or Mark of Applicant	Social Security Number	Date	Phone
Signature of Witness to Mark, Interpreter, or other person.		Date	Phone

Enclosure 3

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES

TRANSITIONAL
MEDI-CAL
NOTICE OF ACTION
DISCONTINUANCE OF BENEFITS

(County Stamp)

Case No.: _____

District: _____

This affects:

_____
Name(s)

Your benefits under Transitional Medi-Cal will be discontinued effective the last day of _____.
(Month)

The reason for this discontinuance is:

In order for you to remain eligible and/or be reconsidered for Medi-Cal benefits, you must contact this office within 10 days of the date of this notice.

The regulations which require this action are California Code of Regulations, Title 22, Sections 50244 and 50244.5.

_____ _____ _____
(Eligibility Worker) (Phone) (Date)

MC 239 TMC 2 (4/90)

Enclosure 4

TRANSITIONAL
MEDI-CAL
NOTICE OF ACTION
APPROVAL FOR BENEFITS

(County Stamp)

CASE No: _____

District: _____

This affects: _____

TRANSITIONAL MEDI-CAL IS A PROGRAM THAT PROVIDES CONTINUING MEDI-CAL BENEFITS, FOR RECIPIENTS DISCONTINUED FROM AFDC AS A RESULT OF EMPLOYMENT, FOR A MAXIMUM OF 12 MONTHS.

We have reviewed your eligibility for Transitional Medi-Cal.

You are entitled to receive Transitional Medi-Cal beginning the first day of _____ (Month). You will continue to receive a Medi-Cal card for at least six months as long as you have a child in the home.

Attach verification of your family's monthly gross earnings and the actual child care costs you paid.

You must report any changes in your income, property, family composition, and cost for child care within 10 days of the change.

Always present your Medi-Cal card to your doctor or any other Medi-Cal provider when you are requesting medical services.

The regulations which require this action are California Code of Regulations, Title 22, Sections 50244 and 50244.5.

_____ (Eligibility Worker) _____ (Phone) _____ (Date)

State of California

Department of Health Servi

Memorandum

Ron Wetherall, Chief
Office of Regulations
Attention: Mary Conway
8/1000

Date : APR 2 6 1990

Subject: R-11-90,
Transitional Medi-Cal
(Emergency)

From Medi-Cal Policy Division
8/1561 5-6141

Attached for review and processing is new emergency regulation package R-11-90. These regulations must be filed with the Secretary of State in time to take effect April 1, 1990 as required by the mandating legislation.

This regulation package repeals Subsection 50244; adopts Sections 50244, and 50244.5; and amends Sections 50137 and 50179.5, Title 22, CCR. These regulations implement the Federal Family Support Act of 1988 (Public Law 100-485) and Assembly Bill 894 (Ch 1016, Statutes of 1989) by providing transitional Medi-Cal eligibility to families who were discontinued from AFDC due to an increase in earnings, an increase in the number of hours worked, or the loss of the $30 plus one-third or the $30 earned income disregard.

These regulations are expected to increase State General Fund expenditures by $5,950,350 and to increase Federal cost by $5,950,350. These regulations do not impose a new mandate on school districts or other local government agencies which must be reimbursed by the State, and they are not expected to result in cost to private persons or small businesses.

These regulations are not expected to result in controversy because they implement federal statute. No Director's decision is needed.

Section 2 of AB 894 grants emergency authority for these regulations, but it does not exempt them from OAL review.

Kristi Allen (5-6855) is the MEB contact for this package.

Original signed by

Virgil J. Toney, Jr.
Chief

Attachment

INFORMATIVE DIGEST

Current Medi-Cal Regulations in Division 3, Title 22, California Code of Regulations (CCR) provide that persons discontinued from AFDC due to an increase in earnings or in the number of hours worked will receive continuing zero share of cost Medi-Cal for four months following discontinuance from AFDC. Families discontinued from AFDC due to the loss of the time limited $30 plus one-third or $30 earned income disregard currently receive nine months of zero share of cost Medi-Cal.

Section 303(a)(1) of the Family Support Act of 1988 (Public Law 100-485) added Section 1925 to the Social Security Act hereinafter cited as Section 1396s, Title 42, United States Code (42 USC 1396s). This new federal statute amended federal Medicaid policy. Under current law, persons discontinued from AFDC cash grant status due to increased earnings or an increase in hours of employment are eligible for four months of continuing zero share of cost Medicaid. Those families discontinued due to the loss of earned income disregards are eligible for nine months of continuing zero share of cost Medicaid. New federal statute 42 USC 1396s combines both of these groups into one Transitional Medicaid Category and provides an initial six month period of zero share of cost Medicaid, followed by an additional six month period, if the family meets all other conditions of eligibility.

Section 2 of Assembly Bill (AB) 894 (Chapter 1016, Statutes of 1989) adopted Section 14005.8 of the Welfare and Institutions (W & I) Code to change California's Medi-Cal policy to comply with this new federal Medicaid policy stated in section 42 USC 1396s.

This regulation package repeals Section 50244; adopts Sections 50244 and 50244.5 and amends Sections 50137, 50179.5, Title 22, CCR to implement, interpret, and make specific Sections 14005.8, W & I Code, and 42 USC 1396s. Specific changes are discussed below:

Section 50137 (3) is added to establish the date in which a TMC Medi-Cal case is to be transferred to a new county of responsibility.

Section 50179.5 is being amended to include the requirement at 42 USC 1396s that mandates that persons be notified of their eligibility for Transitional Medi-Cal (TMC) in the AFDC notice of discontinuance.

Section 50243 is being amended to continue the provisions of this section indefinitely. It previously was to have ended on September 30, 1988.

Section 50244 is being repealed as the existing Nine Month Continuing Category is being replaced by the Transitional Medi-Cal (TMC), Initial and Additional Six Month Categories. This section is being re-adopted to establish standards for the TMC, Initial Six Month Category.

Section 50244.5 is being adopted to establish standards for the TMC Additional Six Month Category.

INITIAL STATEMENT OF REASONS

This regulation package repeals Section 50244; adopts Sections 50244 and 50244.5; and amends Sections 50137 and 50179.5, Title 22, CCR to comply with Section 14005.8 of the Welfare and Institutions (W & I) Code, as it was adopted by Section 2 of Assembly Bill (AB) 894 (Chapter 1016, Statutes of 1989) and Section 1925 of the Social Security Act, hereinafter cited as Section 1396s, Title 42, United States Code (42 USC 1396s) as it was added by Section 303(a)(1) of the Family Support Act of 1988 (Public Law 100-485).

Section 50137 currently precludes counties from transferring a continuing four or nine month Medi-Cal case to another county. This change is needed to comply with Subsection 14005.8 W & I code, which requires that TMC benefits be continued uninterrupted for a minimum of six months.

Section 50137 (3) is being added to allow for a Medi-Cal case to be transferred to a new county of residence on the last day of the month in which the 30th day after notification to the new county of the change in county of responsibility occurs.

Section 50179.5 does not address the notice of action requirements in the Family Support Act. The Act requires that a notice outlining a person's eligibility for Transitional Medi-Cal be provided at the time that AFDC cash is discontinued. Section 50179.5 is being amended to address this requirement. This change is needed to comply with Section 1396s, Title 42, United States Code, which requires that the AFDC discontinuance notice provide transitional Medi-Cal (TMC) information.

Section 50243 currently provides Four Month continuing Medi-Cal to persons who were discontinued from AFDC due to the increased collection of child/spousal support beginning August 1, 1984 and ending September 30, 1988. Section 50243 is being amended to delete these dates. The Omnibus Reconciliation Act of 1989 (OBRA-89) provides that this program must be continued indefinitely with no time restrictions.

Section 50244 currently provides Nine Months of continuing Medi-Cal eligibility to persons who were discontinued from AFDC solely due to the expiration of the time limited income disregards.

Section 50244 is being repealed and readopted to eliminate reference to the Nine Month Continuing Eligibility Category and to include the new Transitional Medi-Cal Initial Six Month category mandated by the 42 USC 1396s.

Section 50244.5 is being adopted to implement the Transitional Medi-Cal Additional Six Month category mandated by 42 USC 1396s.

These changes are required by Section 2 of AB 894 (Chapter 1016, Statutes of 1989) and Section 14154.2 W & I Code which requires the state to comply with federal Medicaid Standards in order to maximize federal financial participation (FFP). If these changes are not implemented, California's Medi-Cal regulations will not comply with federal Medicaid Standards, resulting in Quality Control sanctions and resulting loss of FFP.

LOCAL MANDATE STATEMENT

These regulations will impose no new mandate on school districts which must be reimbursed pursuant to Section 17500 et seq. of the government code.

IMPACT ON SMALL BUSINESSES AND PRIVATE PERSONS

These regulations are not expected to negatively impact small businesses or private persons.

STATEMENT OF ALTERNATIVES

The Department did not consider alternatives to regulations as Section 2 of Assembly Bill 894 (Chapter 1016, Statutes of 1989) required the Department to adopt emergency regulations. The Department has determined that no alternative to regulations would be more effective or less cumbersome to affected persons.

FINDING OF EMERGENCY

Section 2 of Assembly Bill 894 (chapter 1016, Statutes of 1989) added Subsections 14005.8(f) and (g) to the Welfare and Institutions Code, which requires the Department to adopt these emergency regulations to take effect April 1, 1990 to comply with Title Six of the federal Social Security Act (Section 1396 et seq, Title 42, United States Code). If these regulations do not take effect April 1, 1990 as required, California's Medi-Cal policy in Division 3, Title 22, California Code of Regulations (CCR) will not comply with federal Medicaid policy in Section 1396s, Title 42, USC. Non compliance will leave the Department subject to potential quality control sanctions and resulting loss of federal financial participation. In a time of fiscal constraint such as this, loss of federal financial participation could seriously jeopardize the Department's ability to provide health care services through the Medi-Cal program to those Californians who are least able to afford the high cost of medical care. For this reason the Department has found that emergency implementation of these regulations by April 1, 1990 is necessary for the immediate preservation of the public health and general welfare. The Department requests emergency filing of these regulations by April 1, 1990 pursuant to Section 11346.1(b) of the Government Code.

Amend Section 50137(a), Title 22, CCR

50137. Intercounty Transfer -- Effective Date of Discontinuance/ Eligibility. (a) In a change in county of responsibility, the effective date of discontinuance, as determined by the initiating county department, shall be the last day of the month in which the 30th day after notification to the new county of responsibility occurs, except that:

(1) No change

(2) No change

(3) If the person or family is receiving Medi-Cal under the Transitional Medi-Cal--Initial Six Month or Additional Six Month Continuing eligibility categories, the effective date of the discontinuance is the last day of the month in which the 30th day after the notification to the new county of responsibility occurs.

(b) No change

(c) No change

Authority: Sections 10725, 14005.8, and 14124.5 Welfare and Institutions Code.

Reference: Sections 1104, 14005.8, and 14016, Welfare and Institutions Code; and Section 1396s, Title 42, United States Code.

Amend Section 50179(c), Title 22, CCR

50179.5. Notice of Action -- County Cash Assistance Determinations or Redeterminations Which Affect County Cash-Based Medi-Cal Eligibility.

A Notice of Action of discontinuance of county cash-based Medi-Cal shall include notice that one of the following actions has been taken:

(1) The family has been determined eligible to receive Medi-Cal benefits through the Transitional Medi-Cal -- Initial or Additional Six-Month Categories.

(1)2 A referral for determination of Medi-Cal eligibility under another program is being made and notification of that determination will follow.

(2)3 A Medi-Cal-only determination has been made and the specific results of that determination.

(3)4 County cash-based Medi-Cal is being discontinued for one of the reasons stated in Section 50183, and a determination of Medi-Cal-Only eligibility will require a separate application.

(4)5 A cash grant or IHSS is being discontinued due to failure of the recipient to submit data on current status, via monthly AFDC eligibility and income reports, or another approved method. Medi-Cal eligibility under any program will automatically be reevaluated only if the data is provided by the effective date of the notice.

(5)6 Additional information is required to permit completion of a Medi-Cal only determination. The information required may include the person's wishes concerning continued Medi-Cal eligibility. The county department may require that the person provide the information by a specific date.

Authority: Sections 10725, 14005.8, and 14124.5, Welfare and Institutions Code.
Reference: Sections 1104, 14005.8, and 14016, Welfare and Institutions Code; and
Section 1396s, Title 42, United States Code.

Amend Section 50243(a)(b), Title 22, CCR

50243. Four Month Continuing Eligibility Category

(a) The Four Month Continuing Eligibility Category includes persons who were discontinued from AFDC due wholly or in part to the collection or increased collection of child/spousal support.

(b) Eligibility for the Four Month Continuing Eligibility Category based wholly or in part on the collection or increased collection of child/spousal support, shall continue for a period of four months following the most recent month in which the family became ineligible for AFDC.

Authority: Sections 10725, 14005.8, and 14124.5 Welfare and Institutions Code.

Reference: Sections 1104, 14005.8, and 14016 Welfare and Institutions Code; and Section 1396s, Title 42 United States Code.

Repeal Section 50244, Title 22, CCR

~~50244.----Nine--Month--Continuing--Eligibility.--(a)--The--Nine---Month continuing--category--includes-persons-who-were-discontinued--from--AFDC--due solely--to-the-expiration-of-the-$30-plus-1/3-or-$30-earned-income--disregard specified-under-that-program.~~

~~(b)---Eligibility--under-this-category-shall-continue-for-a--period--of nine--consecutive-months-following-the-most-recent-month-in-which-the--family became--ineligible--for-AFDC,-regardless-of-whether-the-other--conditions--of eligibility-are-met.~~

~~(c)---The--provisions--of--this-regulation-also--apply--to--eligibility determinations-or-redeterminations-made-retroactively-to-October-1,-1984.~~

Adopt Section 50244, Title 22, CCR

50244. Transitional Medi-Cal -- Initial Six Month Eligibility Category

(a) The Initial Six-Month Eligibility Category is a Medi-Cal program which includes persons who were discontinued from AFDC due solely to any of the following:

(1) Increased earnings from employment of the caretaker relative,
(2) The principal wage earner returned to work, or
(3) The $30 plus one-third or $30 earned income disregard expired.

(b) The Initial Six-Month Eligibility Category does not include persons who were discontinued from AFDC due to any of the following:

(1) A stepparent contribution,
(2) An increase in a stepparent contribution,
(3) The return of an absent parent to the home, thus ending deprivation,
(4) The stepparent's ability to meet the needs of the parent.

(c) To be eligible for the Initial Six-Month Eligibility Category, members of the family must have received an AFDC cash grant in at least three of the six months immediately preceding the month in which they became ineligible for AFDC. A "family" means the members of the AFDC-FBU in the month in which the family was discontinued from AFDC.

(d) Eligibility for the Initial Six Month Eligibility Category based on increased earnings, hours of employment or the expiration of the earned income disregard, shall continue, without reapplication, for a period of six months beginning with the month the family became ineligible for AFDC, unless the family no longer includes at least one child as defined in Section 50030. If there is no child in the family, eligibility for assistance under this section is to be discontinued at the end of the month in which the last child ceases to reside in the home, so long as timely notice is provided.

Prior to discontinuing Medi-Cal eligibility the county shall:

(A) Determine whether the child is eligible to receive Medi-Cal under another program,

(B) Provide a timely notice of action, explaining the reasons for discontinuance,

(e) By the 21st day of the fourth month of the initial six-month period the family members shall provide the county department with a status

report which covers each of the three preceding months and includes for each month:

(1) The names and ages of the persons residing in the household.

(2) The gross monthly earnings of the family, including the earnings of any parent(s) who return to the home during the receipt of Transitional Medi-Cal. The earned income of a student who is a family member shall be subject to the provisions of Section 50543.

(3) The actual cost, paid by the caretaker relative, for obtaining child care necessary for employment of the caretaker relative.

Child care expenses which are reimbursed by the State or by any other source shall not be deducted from income.

(f) As used in Sections 50244 and 50244.5 "caretaker relative" means the person in the home responsible for the care and control of a child. A caretaker relative must be one of the following:

(1) The father, mother, brother, sister, half-brother, half-sister, uncle, aunt, first cousin, nephew, niece, or any such person of a preceding generation denoted by the prefixes grand, great, great-great.

(2) The stepfather, stepmother, stepbrother, or stepsister.

(3) The spouse of any person specified in (1) or (2) even if the marriage has been terminated by death or dissolution.

(g) Unless it is established that the family has good cause as defined in Subsection (h)(2) below, Medi-Cal benefits shall not be approved for the Additional Six Month Eligibility Category, as defined in Section 50244.5, if the family's status report is not received by the county department by the 21st day of the fourth month of the Initial Six-Month period.

(h) A beneficiary may have good cause for not meeting the Transitional Medi-Cal status report requirements during either the initial or the additional six month continuing eligibility period. Good cause exists only when the beneficiary cannot reasonably fulfill his/her reporting responsibilities due to factors outside his/her control. The burden of proving good cause rests with the beneficiary.

(1) Only a parent, other caretaker relative or an authorized representative may request a good cause exemption.

(A) "Request," as used in this Section, means any written or oral communication to the county that the beneficiary wants an opportunity

to explain why he/she cannot meet the TMC status report requirements.

(2) In lieu of a request, as required in (A) above, the county may independently determine that one of the following reasons for good cause exists:

(A) The beneficiary is suffering from a mental or physical condition which prevents timely and complete status reporting.

(B) The beneficiary's failure to submit a timely and complete status report is directly attributable to a county error.

(C) The county finds other extenuating circumstances.

(3) When the county determines that the beneficiary had good cause for not reporting timely, the county shall rescind its discontinuance of eligibility.

(i) During the third and sixth months of the initial six-month period the county department shall notify the family of the availability of the additional six month Eligibility Category described in Section 50244.5.

(1) During the third month of the initial six-month period the notice shall describe: (A) the information necessary to meet the reporting requirement in (e).

(2) During the sixth month of the initial six-month period the notice shall describe:

(A) The information necessary to meet the reporting requirements of Section 50244.5

(B) The amount of the beneficiary's share of cost, if any, and

(C) Any benefit limitations or restriction of services that may exist.

Authority: Sections 10725, 14005.8, and 14124.5 Welfare and Institutions Code

Reference: Section 14005.8 Welfare and Institutions Code; and Section 1396s, Title 42, United States Code.

Adopt Section 50244.5, Title 22, CCR:

50244.5 Transitional Medi-Cal-Additional Six-Month Category.

(a) Medi-Cal benefits may be continued for an additional six month period for each family who received assistance under Section 50244 during the entire initial six month period unless one of the following occurs:

(1) The family no longer includes a child as defined in Section 50030.

(2) The caretaker relative is unemployed during one or more of the preceding three months, unless the unemployment is a result of one of the following:

(A) Involuntary loss of employment.

(B) Illness.

(C) Other good cause as defined in Section 50244(h).

(3) The family's average gross earnings (less the actual costs for child care) as defined in Section 50244(e)(3) exceed 185% of the federal poverty level.

(4) The family fails to meet the mandatory reporting requirements of Section 50244(e).

(b) By the 21st day of the first month and the 21st day of the fourth month of the additional six-month period the family must provide the county department with a status report which covers each of the three preceding months. The report shall include for each month:

(1) The gross monthly earnings of the family including the earnings of any parent(s) who return to the home during the receipt of Transitional Medi-Cal. The earned income of a student who is a family member shall be subject to the provisions of Section 50543.

(2) The actual cost paid by the caretaker relative for child care as specified in 50244(e)(3).

(c) During the third month of the additional six-month period the county department shall notify the family of the reporting requirements in Section 50244.5(b) and any share of cost that may apply.

(d) Medi-Cal benefits shall be discontinued at the end of the first or fourth month of the additional six-month period if any one of the items listed in Section 50244.5(a) occurs. Aid paid pending shall be provided to children who are discontinued from TMC.

(e) A ten-day notice of action shall be provided prior to discontinuance for any of the reasons stated in (a).

(f) Medi-Cal benefits may not be discontinued until eligibility is determined under another program.

Authority: Section 10725, 14005.8, and 14124.5, Welfare and Institutions Code.

Reference: Section 14005.8 Welfare and Institutions Code; and Section 1396s, Title 42, United States Code