STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

August 7, 1987

TO: All County Welfare Directors
All County Administrative Officers

Letter: 87 - 43

SUBJECT: RECENTLY FILED NONEMERGENCY REGULATIONS

Enclosed is an advance copy of recently filed regulation revisions (Attachment I) which become effective on August 8, 1987. These revisions will be issued to all holders of the Medi-Cal Eligibility Manual in the near future.

Most of the revisions are clarifying in nature and therefore do not represent a change in policy. The substantive changes are discussed below.

Section 50167 - Verification of Income In Kind

Verification will now be limited to those items which the applicant claims have a lower value than the standard values established in accordance with 22, CAC, Section 50511.

Section 50213 - Absent Parent Deprivation: Active Duty In The Uniformed Services

Existing regulations set forth conditions under which parental absence due to active duty in the Armed Forces constitutes deprivation even though there is no break in family ties. Such absence will no longer constitute deprivation for establishing linkage to AFDC.

The provisions of this revision should be applied immediately at Intake commencing with August, 1987 month of eligibility. Continuing AFDC-MN cases should be reviewed for impact along with the review of the next status report received for each individual case. The effect of this change is that the parent in the home may become an ineligible member of the MFBU and the children may change from AFDC-MN to Medically Indigent children.

If you have any questions regarding these regulations, please contact Ruthell Ussery of my staff at (916) 322-6238, ATSS 8-492-6238. If you are unable to implement the provisions of 22, CAC, Section 50653.5 by November 1, 1987, please contact your DHS Corrective Action Liaison.

Sincerely,

Original signed by

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Expiration Date: November 30, 1987

Sections 50653.5 and 50015 - Voluntary Inclusion Of Additional Family Members In The MFBU Which Results In An Increased Share Of Cost

The revisions to these regulations may or may not represent a substantive change in your county. Current regulations specify that an increased share of cost resulting from the voluntary inclusion in the MFBU of an excluded family member is not an adverse action. Current regulations provide no guidance regarding the accomplishment of the increase nor do they address the inclusion of family members entering the home. As a result counties may have developed various methods for handling this situation.

The revision to Section 50015 broadens the scope of the voluntary inclusion provision. The revisions to Section 50653.5 specify that the entire MFBU is assigned the higher share of cost when the original members have not received Medi-Cal cards for the month or their Record of Health Care Costs, form MC 177S, for the month has not been sent to the Department. If Medi-Cal cards have been issued or the MC 177S has been sent to the State, then the newly added family member is assigned a share of cost equal to the difference between the share of cost calculated for the MFBU including the newly added member and the share of cost calculated for the original MFBU members. Attachment II contains detailed instructions for this process which will be issued in the Procedures Portion of the Medi-Cal Eligibility Manual.

These provisions should be implemented as soon as possible if you are not already treating increased shares of cost due to the addition of family members in the manner described above. If you are unable to accomplish implementation by November 1, 1987 please contact your DHS Corrective Action Liaison to establish a mutually acceptable implementation date.

Section 50743 - Issuance of Medi-Cal Cards To SSI/SSP Recipients

The one-year limitation on card issuance pursuant to 22, CAC, Section 50746 now applies to SSI/SSP recipients. Please note the instructions contained in All County Welfare Director's Letter No. 86-79 are still applicable, except that issuance of an SSI/SSP-based Medi-Cal card more than one year after the date of service is now prohibited unless one of the conditions in Section 50746 exist.

(C) Admission to an institution which renders the beneficiary ineligible.

(D) The beneficiary also has Medi-Cal eligibility under another identity or category, or in another county or state; or will have such dual eligibility as of the first of the coming month if discontinuance action is not taken.

(E) Receipt of the beneficiary's clear and signed written statement that does either of the following:

1. States the beneficiary no longer wishes Medi-Cal benefits.

2. Gives information that requires discontinuance and includes the beneficiary's acknowledgement that this must be the consequence of supplying such information.

(2) An increase in an MFBU's share of cost due to either of the following:

(A) The voluntary inclusion of eligible family members who currently are not receiving benefits under any Medi-Cal program.

(B) Receipt of the beneficiary's clear and signed statement which gives information which requires an increase in the share of cost and includes the beneficiary's acknowledgement that this must be the consequence of supplying such information.

50016. Aid. Aid means cash assistance, food stamps or Medi-Cal.

50017. Aid Category. Aid category means the specific category under which a person is eligible to receive Medi-Cal.

Article 4. Application Process

50141. Application Process -- General. The county department shall receive and act upon all applications, reapplications, requests for restoration and redeterminations without delay and in accordance with the provisions of this article.

50142. Screening. (a) County departments that have established a procedure for screening potential applicants prior to application shall:

(1) Determine the Medi-Cal program under which the person or family should be processed.

(2) Provide information regarding Medi-Cal eligibility requirements to all persons being screened.

(3) Inform each person being screened of that person's rights under the Medi-Cal program, even if it appears that the person is ineligible. Rights of Persons Requesting Medi-Cal, MC 216, shall be explained to, and signed by, the person being screened.

(A) The original shall be retained by the county department. If the person being screened does not apply for Medi-Cal, the form shall be retained for at least 90 days.

(B) A copy shall be given to the person being screened.

50143. Persons Who May File an Application for Medi-Cal. (a) Any person who wishes to receive Medi-Cal may file an application. If the applicant for any reason is unable to apply on his own behalf, or is deceased, any of the following persons may file the application for the applicant.

(1) The applicant's guardian or conservator or executor.

(2) A person who knows of the applicant's need to apply.

(3) A public agency representative.

50145. Medi-Cal Application for Persons Applying for a Cash Grant or In-Home Supportive Services. (a) A person or family applying and approved for any public assistance program as specified in Section 50227 or In-Home Supportive Services shall not be required to submit a separate application for Medi-Cal. Medi-Cal eligibility is established automatically.

(b) A person or family specified in (a) may also apply for retroactive Medi-Cal in accordance with Section 50148.

50147. Application for Medi-Cal-Only. (a) A person or family applying for Medi-Cal-only shall submit a completed application form to the county department.

(b) The county department shall, within 30 days of receipt of a referral from the Department pursuant to 50183.5, contact an ABD person in a long-term care facility and assist the ABD person with the completion of an application form for Medi-Cal-only.

(1) An application for Medi-Cal-only shall be completed when:

(A) The ABD person has been in long-term care for more than the month of admission and is expected to remain in the facility for at least 30 days.

(B) The ABD person has nonexempt monthly gross income in excess of $44.90.

(2) The county department shall advise the Department immediately that an inappropriate referral has been received when the conditions in (1) do not exist.

50148. Application for Retroactive Medi-Cal. (a) A person or family applying for retroactive Medi-Cal shall:

(1) Submit a completed application form to the county department, if the application is for retroactive coverage only.

(2) Request retroactive coverage in one of the following ways if the request for retroactive Medi-Cal is made in conjunction with, or after, an application for public assistance or Medi-Cal:

(A) On the application form.

(B) On the Statement of Facts.

(C) By submitting a written request.

(b) An application for retroactive coverage pursuant to (a) (2) must be submitted within one year of the month for which retroactive coverage is requested.

50149. Application Form. (a) An application for Public Social Services shall be used as the application form for all Medi-Cal applications.

(b) The original of the completed form shall be placed in the case file.

(c) A copy of the completed form shall be given to the applicant at the time of application.

(d) Only one person's signature shall be required on the application or any other forms necessary to complete the eligibility determination.

(e) A new application form shall not be required for:

(1) Requests for restoration of aid.

(2) Interprogram transfers.

(3) Intraprogram status changes.

(4) Request to add a family member to the Medi-Cal case.

(5) Redeterminations.

4. Children requesting Medi-Cal for minor consent services in accordance with Section 50147.1.

5. MI children who are not living with a parent or relative and for whom a public agency is assuming financial responsibility in whole or in part.

6. Not acting on their own behalf and a government representative, such as a public guardian, is acting for them.

7. The spouse of a person whose identity has been verified.

(7) The following income and resources:

(A) Unearned income, which shall be verified by viewing any of the following:

1. Checks, or copies of checks. County departments shall not require copies of checks issued by the United States Government.

2. Award letters.

3. Signed statements from persons or organizations providing the income.

4. Check stubs.

5. Statements from checking, savings or trust fund accounts which indicate that the income is directly deposited for the applicant or beneficiary by the persons or organizations providing the income.

6. The statement of the person completing the Statement of Facts, for income received from the United States Government. This statement shall constitute verification pending receipt by the county department of verification from appropriate government agency, when the verification in 1 through 5 cannot be provided.

(B) Income in kind, which shall be verified by a written statement from the provider of the items of need. Verification shall be limited to those items which the applicant is claiming have a lower value than the values established in accordance with Section 50511 (b).

(c) The following persons shall be linked to AFDC on the basis of this deprivation factor:

(1) The children of an incapacitated parent.

(2) The incapacitated parent.

(3) The spouse of the incapacitated parent or the second parent of the children whose basis of deprivation is an incapacitated parent.

50213. Deprivation -- Absent Parent. (a) Deprivation of parental support or care exists if there is continued absence of one or both of a child's parents from the home.

(b) Deprivation does not exist when one or both of the parents is absent from the home on a temporary basis, such as for a:

(1) Visit.

(2) Trip.

(3) Temporary assignment undertaken in connection with current or prospective employment.

(4) Parental absence due solely to active duty in the uniformed services of the United States. Uniformed services means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration and Public Health Service of the United States.

(c) Continued absence shall constitute deprivation if the absence is both:

(1) Of such a nature as to interrupt, terminate or preclude the parent's functioning as the provider of maintenance, physical care or guidance for the children.

(2) Of a known or indefinite duration which would preclude counting on the parent's performance of the function of planning for the present support or care of the children.

(d) If the parent in the home has stated on the Statement of Facts that the other parent has left the family, this shall be considered to mean that there is continued absence unless the county department has conflicting information. In the case of conflicting information, the written statement shall be supported by at least one of the following:

(1) Written statements of the absent parent or other persons with prior knowledge of the family relationship.

(2) The actions of the applicant or beneficiary or the absent parent clearly indicate:

(A) Physical absence of the other parent.

(B) Interruption of or marked reduction in marital and family responsibilities.

(3) Other evidence that substantiates continued absence.

(e) Children of an absent parent, and the parent in the home, shall be linked to AFDC on the basis of this deprivation factor. If the parent in the home is married, and the spouse also has children from a prior union, the following persons shall be linked to AFDC:

(1) The children of each parent, other than mutual children.

(2) Both parents.

50489. Property Held in Trust. (a) Real or personal property held in trust for the applicant or beneficiary shall be exempt if the applicant or beneficiary cannot obtain access to the principal of the trust.

(b) To determine whether the trust is available, the applicant or beneficiary shall take whichever of the following actions is appropriate within 30 days of being advised by the county department of the responsibility to do so.

(1) Request the trustee to release the funds.

(2) Request that the trustee petition the court for the release of the funds.

(3) Petition the court directly if the trustee refuses to take the action specified in (1) or (2).

(c) The trust shall be exempt pending completion of the action specified in (b).

(d) The trust shall be included in the property reserve, or considered as other real property, under either of the following conditions:

(1) The applicant or beneficiary refuses to initiate the action specified in (b).

(2) The court determines that the trust is available to the applicant or beneficiary.

(e) The provisions of this section shall not apply if the trust agreement clearly specifies that the applicant or beneficiary is the income-beneficiary only and has no ownership interest in the corpus of the trust.

50515. Unavailable Income. (a) Income which is not available to meet current needs of a person or family shall not be considered in determining that person's or family's share of cost. Unavailable income includes, but is not limited to, the following:

(1) That portion of Worker's Compensation and other public or private insurance settlements which is either of the following:

(A) Designated for medical, legal other such expenses.

(B) Not controlled by the applicant or beneficiary or person acting on his behalf.

(2) That portion of a contribution that is both of the following:

(A) From a person living in the household who has no legal responsibility to support, such as an unrelated adult or an adult child.

(B) Used to meet the actual costs of the contributor's share of the housing, utilities, food and other household costs. If actual costs are unavailable, the amounts specified in Section 50511 shall be used. This shall be the difference between the income-in-kind values for the family size with the person included and excluded.

(3) That portion of the monthly income of a medically needy person residing in a licensed board and care facility which is both of the following:

(A) Paid to the facility for residential care and support.

(B) In excess of the appropriate maintenance need level as determined in accordance with Section 50603.

(4) An advance or a reimbursement from an employer to cover expenses necessary for job performance is unavailable to the extent that the advance or reimbursement does not exceed the actual out-of-pocket costs of the employee.

(b) When a person is in LTC and is in his/her own MFBU in accordance with Section 50377, his/her spouse's share of the community property owned income shall be considered unavailable to the LTC person.

(8) Interest income which is received less frequently than monthly and is not exempt as specified in Section 50542 shall be apportioned as follows:

(A) Determine the number of months of the period during which the interest accrued.

(B) Divide the interest income by the number of months in the interest period.

(C) Consider the amount determined in (B) as income in each of the months of the next interest period.

50517.1 Apportionment of Income Exemptions and Deductions. (a) Income exemptions and deductions shall be apportioned over time using the procedures for apportioning income over time.

50518. Fluctuating Income. (a) Fluctuating income shall be determined by estimating the amount to be received in the month unless the conditions of (b) are met. This estimate shall be made considering all of the following:

(1) The income pattern over the last year.

(2) The actual income received in the last month.

(3) The beneficiary's statement of anticipated income.

(b) Actual income shall be used if it is known at the time the share of cost determination is being made. In no instance shall the share of cost determination be delayed solely to determine the actual income.

(c) The provisions of this section shall not apply to income from self-employment which shall be determined in accordance with Section 50505 or apportioned in accordance with Section 50517 (a) (5).

50519. Income Exemptions and Deductions — General. (a) Certain items of earned and unearned income shall be exempt from consideration in determining a beneficiary's share of cost. Income which remains after the application of the exemptions specified in Sections 50523 through 50544 shall be nonexempt income.

(b) Certain amounts of income shall be deducted from nonexempt income to determine the net income to be used in determining the share of cost. Income which remains after the application of the deductions specified in Sections 50547 through 50555.2 shall be net nonexempt income.

(c) Exemptions and deductions do not apply uniformly to all MN and MI categories nor to both earned and unearned income. Restrictions are stated where applicable.

50521. Payments Exempt from Consideration as Income. Income specified in Section 50523 through 50544 shall be exempt. These exemptions shall apply to all MN and MI persons, unless otherwise specified.

50523. Property Tax Refunds. Refunds or rebates of taxes on real property shall be exempt.

50554. Court Ordered Alimony or Child Support. (a) Court ordered alimony or child support, or child support paid pursuant to an agreement with a district attorney, shall be deducted from the income of an AFDC-MN or MI beneficiary when it is actually paid by that beneficiary.

(b) The amount deducted shall be the lesser of the amount:

(1) Actually paid.

(2) Specified in the court order or agreement with a district attorney.

50554.5. Child/Spousal Support Received by AFDC-MN and MI Family Members. (a) Fifty dollars per month shall be deducted from the total of all child/spousal support received by AFDC-MN and MI family members, whether provided voluntarily or by court order.

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

50555. Deductions from any Income — All MN or MI Programs. The deductions specified in Sections 50555.1 through 50555.2 shall be subtracted from any nonexempt income that remains after the application of all preceding exemptions and deductions.

50555.1. Income of an MN or MI Person Used to Determine Public Assistance Eligibility of Another Family Member. (a) That portion of the income of an MN or MI person or a person responsible for the MFBU which is counted in determining the eligibility of a spouse, parent or child as a PA or Other PA recipient shall be deducted.

(b) Income of a stepparent and the value of income in kind provided by a stepparent which is counted in determining the eligibility of a spouse or stepchildren as PA or Other PA recipients shall be deducted.

50561. Treatment of Income -- Stepparent Cases. (a) If there is a stepparent living in the home, and only the parent and the parent's separate children are included in the MFBU, the income considered in determining the share of cost of those children shall be:

(1) The income of the children.

(2) The income of the parent.

(3) The income available from the stepparent as determinec in accordance with Section 50559.

50563. Treatment of Income -- Aged, Blind or Disabled MN Person or Person's Spouse in LTC or Board and Care. (a) When an aged, blind or disabled MN person or the spouse of that person is in LTC or board and care and that person has a spouse and/or children who are not public assistance recipients, the income of that person shall be treated in the following manner, beginning the first of the month the spouses, or the parent and children, are in separate MFBUs:

(1) The net nonexempt income of the person in LTC or board and care which is in excess of the appropriate maintenance need for that person in accordance with the provisions of Article 11 of this chapter shall be allocated to the spouse and/or children as follows:

(A) When the family is applying for Medi-Cal, determine the maintenance need for the spouse and/or children other than any children excluded from the MFBU.

(B) When only the person in LTC or board and care is applying for Medi-Cal, determine the maintenance need for the spouse and/or all the children.

(C) Subtract the net nonexempt income of the spouse and/or children, other than the excluded children, from the amount determined in (A) or (B). This is the amount that shall be allocated to the spouse and/or children from the net nonexempt income of the MN person in LTC or board and care which is in excess of the maintenance need as determined in (1).

(1) Make the necessary changes in the ongoing share of cost by the first of the month following the month in which the change was reported.

(2) Not make an adjustment for the excess income the beneficiary may have paid or obligated prior to county action specified in (b) (1) unless the county department determines that there was good cause for failure to report in a timely manner. Good cause shall be determined in accordance with Section 50175.

(c) When it is determined in accordance with (a) or (b) that there has been a decrease in the share of cost which is to be adjusted, the adjustment shall be made in accordance with the following:

(1) The period of adjustment shall begin with the month the county department takes action in accordance with (a) or (b), and shall terminate when the total adjustment has been made.

(2) The amount of the adjustment is the difference between the original share of cost and the corrected share of cost.

(3) The amount of the adjustment or a portion of the adjustment equal to the share of cost shall be subtracted from the share of cost each month until the adjustment is completed.

50653.5. Changes Which Increase the Share of Cost. (a) In situations where a change in income or other circumstances, which results in an increase in the share of cost, is reported by the beneficiary in a timely manner, as specified in Section 50185, the county department shall make necessary changes effective:

(1) Immediately, if the increase is due to the voluntary inclusion of a family member who has income. The share of cost to be met shall be either of the following:

(A) The total increased share of cost shall be met by all members of the MFBU providing Medi-Cal cards have not been issued for the share-of-cost month and form MC 177S has not been submitted to the Department in accordance with Section 50658 (c).

(B) The difference between the increased share of cost and the former share of cost shall be met by the newly included family member(s) when Medi-Cal cards have been issued for the share-of-cost month or form MC 177S has been submitted to the Department in accordance with Section 50658 (c).

(2) In accordance with the following, in all other instances:

(A) The first of the month following the month in which the change was reported, if a 10 day notice can be given.

(B) The first of the second month following the month in which the change was reported, if the change cannot be made in accordance with (A).

(b) In situations where a change in income or other circumstances, which results in an increase in the share of cost determination, is not reported by the beneficiary in a timely manner, as specified in Section 50185, the county department shall:

(1) Make the changes to the ongoing share of cost in accordance with (a).

(2) Determine what the share of cost should have been for the months in which the increase occurred.

(3) Report a potential overpayment in accordance with Section 50781, if the beneficiary:

(A) Received a Medi-Cal card and should have had a share of cost.

(B) Met a share of cost which was less than the corrected share of cost.

50653.7. Changes in Share of Cost Determination Due to Administrative Error. (a) An administrative error which causes the share of cost amount to be in excess of the correct share of cost amount shall be adjusted in accordance with Section 50653.3 (a).

(b) If the county fails to take action on an increase in income within the time frames specified in Section 50653.5, excess income received after the time the county department should have taken action shall not be reported as a potential overpayment.

(f) A final date of eligibility shall be established when the county department determines that the person or family will no longer meet all eligibility requirements as of the first of the following month. The final date shall be the last day of the:

(1) Current month, if the discontinuance is not an adverse action as defined in Section 50015.

(2) Current month, if the discontinuance is an adverse action and the ten day advance notice requirements of Section 50179 (e) will be met in the current month.

(3) Following month, if the discontinuance is an adverse action and the ten day advance notice requirements will not be met in the current month.

50710. Retroactive Eligibility. (a) In addition to the period of eligibility specified in Section 50703, an applicant shall be eligible for Medi-Cal in any of the three months immediately preceding the month of application or reapplication if all of the following requirements are met in that month:

(1) The county department determines that the applicant would have been eligible for one of the programs specified in Section 50201, except as specified in (c), had an application had been made.

(2) The applicant received health services.

(3) The applicant was not previously denied Medi-Cal for the month in question, unless the application was denied for one of the following reasons:

(A) County error.

(B) The applicant's failure to cooperate, when that failure, or the applicant's subsequent failure to reapply, was due to circumstances beyond the control of the applicant.

50743. Medi-Cal Card Issuance by the County Department — No Share of Cost. (a) The county department shall issue a current or past month Medi-Cal card as limited by Section 50746 to each person who meets all of the following conditions:

(1) Is eligible for SSI/SSP. The county department shall verify SSI/SSP eligibility by obtaining information from the SDX data available to the county. If the SDX data on the individual does not appear to be accurate or complete, proof of eligibility shall be any of the following:

(A) The SSI/SSP check for the month for which the card is requested.

(B) Documentation from the Social Security Administration verifying eligibility.

(C) An SSI/SSP award letter received that month.

(D) An approved Title XVI emergency loan for that month.

(E) Other proof of eligibility as specified by the Department.

(2) Is not enrolled in a comprehensive PHP for the month for which a card is requested.

(3) Needs any of the following:

(A) Additional or duplicate POE labels.

(B) A replacement for a mutilated card.

(C) A replacement for a card containing erroneous data.

(D) A replacement Medi-Cal card because the original card was not received. In this case, the SSI/SSP recipient shall complete and sign form MC 110.

(b) The county department may issue current or past month Medi-Cal cards, as limited by Section 50746, to all other Medi-Cal eligibles who meet all of the following conditions:

(1) Do not have a share of cost.

(2) Are not enrolled in a comprehensive PHP for the month for which a card is requested.

(3) Did not receive a Medi-Cal card. In this case, the beneficiary shall complete and sign form MC 110.

(3) An adopted State hearing decision states that, due to a county department or Department administrative error, a Medi-Cal card for a month was not received by the beneficiary.

(4) The Department requests that the Medi-Cal card be issued.

(5) The county department has determined that an administrative error has occurred.

50749. Control of County Issued Medi-Cal Cards. (a) The county department shall record every Medi-Cal card issued or voided by the county department on the Control Log for MC 301, form HAS 2007.

(b) The county department may, with Department approval, use a substitute for form HAS 2007.

(c) The county department shall account for stocks of Medi-Cal cards as required by the Department.

50751. Report of Eligibles. (a) The Department shall compile a monthly report of all persons eligible for Medi-Cal. This Report of Eligibles shall include all persons:

(1) Certified for Medi-Cal by the county department and reported to the Department for issuance of Medi-Cal cards or listing as enrolled in a PHP.

(2) Certified for Medi-Cal and issued Medi-Cal cards by the county department.

12 -- INCREASED SHARE OF COST (SOC) DUE TO VOLUNTARY INCLUSION OF ADDITIONAL FAMILY MEMBERS(S)

The purpose of this section is to provide instructions for processing cases in which there is an increased SOC due to the voluntary inclusion in the Medi-Cal Family Budget Unit (MFBU) of additional family members(s)

1. Background

Title 22, California Administrative Code, Section 50015, specifies that an increased SOC due to the voluntary inclusion in the MFBU of an eligible family member is not an adverse action; therefore, a ten-day advance notice is not required before increasing the SOC. If a financially responsible relative with income returns to the home and does not voluntarily request to be included in the MFBU, a ten-day advance notice is required before the SOC can be increased.

Example: Mrs. T and her two children are receiving Medi-Cal as an Aid to Families with Dependent Children-Medically Needy family due to absent parent deprivation. They do not have an SOC. Mr. T returns to the home on September 5. Based upon his income (DIB), the MFBU will have an SOC. Mr. T does not wish to be voluntarily included in the MFBU. A ten-day advance notice is requried before Mr. T with his income is added to the MFBU. If Mr. T voluntarily requests Medi-Cal for September, a ten-day advance notice is not required, he and his income would be added to the MFBU effective September 1 and an adequate Notice of Action issued.

2. Case Situations

a. Original MFBU has zero SOC; due to voluntary inclusion of an additional family member, MFBU has a $X SOC.

(1) Issue a Record of Health Care Costs form, MC 177S, for month in which voluntary inclusion is requested with $X SOC. List the newly added family member on the form as an eligible member and the original members as ineligible "I.E.". Update Medi-Cal Eligibility Data System (MEDS) to include the newly added family member with $X SOC. Do not change the MEDS records for the original members.

(2) Issue a Notice of Action approving benefits for the newly added family member with $X SOC. Indicate that $X SOC will be for the entire MFBU the following month. (This can be accomplished on a single notice or two separate notices can be used.) A ten-day advance notice is not required. Update MEDS records for following month to show $X SOC for all members of the MFBU.

NOTE: If the addition of the family member occurs late in the month (after county cut-off), step 1 above may be repeated the month following the month of request for voluntary inclusion. By month three, however, the entire MFBU should appear on the MC 177S.

b. Original MFBU has $X SOC; due to voluntary inclusion of an additional family member, the MFBU has an increased SOC of $Y. The MC 177S for the month has not been sent to the Department.

(1) Retrieve the MC 177S issued to the original members of the MFBU. Change the SOC from $X to $Y and add the new MFBU member to the form. Update MEDS to include the newly added family member with $Y SOC. Update MEDS records for original MFBU to reflect $Y SOC.

(2) Issue a Notice of Action approving benefits for the newly added family member and indicating an increase in SOC for the entire MFBU.

c. Same situation as in b. except the MC 177S for the month for the original MFBU members has been sent to the Department.

(1) Issue an MC 177S for the month in which voluntary inclusion requested with ($Y-$X) as the SOC amount (example: the SOC for the original MFBU was $25, the increased SOC is $75; $50 would be listed on MC 177S). List the newly added family member on the form as an eligible member and list the original family members as "I.E.". Update MEDS to include the newly added family member with ($Y-$X) SOC. Do not change the MEDS records for the original members.

(2) Issue a Notice of Action approving benefits for the newly added family member with an SOC of ($Y-$X). Issue a second notice that effective the first of the following month the SOC for the entire MFBU will increase to $Y. A ten-day advance notice is not required. Update the MEDS record for the following month for the entire MFBU to reflect $Y SOC. (The record for the newly added family member will change from ($Y-$X) to $Y; the records for the original members will change from $X to $Y.)

NOTE: If the addition of the family member occurs late in the month (after county cut-off), the following month the original MFBU may be issued an MC 177S with $X SOC and the newly added member issued an MC 177S with ($Y-$X) SOC. By month three, however, the entire MFBU should appear on the same MC 177S with a $Y SOC.

GEORGE DEUKMEJIAN Governor

EPARTMENT OF HEALTH SERVICES
744 P STREET
CRAMENTO, CA 95814

August 7, 1987

To: All County Welfare Directors
All County Administrative Officers

Letter No.: 87- 44

Subject: Cost Avoidance

Reference: All County Welfare Directors Letter 87-28

This is a follow-up letter to the All County Welfare Directors Letter (ACWDL) 87-28 informing the counties of the State's decision to directly update beneficiary records on MEDS with cost avoidance codes, resulting from matches with insurance companies. We had previously informed counties that matches with Blue Cross, Blue Shield, and American General would be completed in time for coding September 1987 cards. However, due to delays in negotiating contracts with Blue Cross and Blue Shield, we will only begin cost avoidance for American General in September. Counties will be notified when the carrier coding for Blue Cross and Blue Shield will occur.

This letter also addresses questions that have been asked by counties and clarifies the counties' role in handling clients who have had cost avoidance codes placed on their Medi-Cal cards by the state.

When will the counties receive notification of the beneficiary records updated with new cost avoidance codes?

Counties with beneficiaries from the American General match will receive either paper listings (one page per beneficiary) or a tape the first week in September. (See attached sample for paper listings and record layout for the tape.) This will be approximately two weeks after the match with the insurance company. The results of the remaining matches will be distributed as soon as each match is completed.

Do the counties have to update their files?

Counties are not required to update their records to match MEDS for the majority of cases. However, because other coverage information is printed on MC 177s, counties should at least update their MC 177 share of cost records so that providers are informed of beneficiaries' cost avoidance coverage identification prior to rendering services.

What beneficiary data elements are being matched against the insurance companies' files?

The State is sending a tape of Medi-Cal eligibles' Social Security numbers (excluding pseudo SSNs) to the insurance companies. The match with insurance company files will be by Social Security number. The insurance companies will return name and date of birth carried on their files. This data will then be compared to MEDS data utilizing the same name, date of birth edits that are used with the Social Security Number Validation process. See September 19, 1987 All Users Coordinator letter for edit criteria.

How will the counties know if the cost avoidance code was placed by the county or the State?

MEDS contains an OHC Source field on the new Pending Medi-Cal and Miscellaneous screen (INQP). This field was previously on page 3 of the Full Status Inquiry screen. This field will automatically show a "T" if the cost avoidance code was input from the matches with the insurance companies, "C" if input by the counties or "H" if input by Health Insurance Unit. Any update to a prior, current or pending Other Coverage field will change the OHC source.

When and how do counties correct cost avoidance OHC code on MEDS?

As stated in ACWDL 87-28, counties will be able to take the client's word as justification for removing the new cost avoidance OHC code ("B" for Blue Cross, "G" for American General, and "S" for Blue Shield). Counties can use an EW15, EW20, EW30 or EW55 transaction (either online or batch) to change an incorrect code when the recipient is active on MEDS for the month in question. An "O" (alpha) OHC code is required on the input transaction. This code will replace the cost avoidance code on MEDS with an "N". If the beneficiary does not have any other coverage, no other steps are needed.

If the OHC code must be changed to a non-cost avoidance OHC code other than "N", two transactions are required. The cost avoidance OHC code must be removed as stated above; the new code may then be added using any existing transactions that change the OHC code. The following procedures are to be used in these instances: (Please note that a card with an OHC code other than "N" cannot be produced on the county printer on the same day an "O" is used to remove a cost avoidance code.)

1. IF THE CLIENT DOES NOT NEED A CARD IMMEDIATELY:

   FOR NON-SSI/SSP BENEFICIARIES:

   The incorrect OHC code can be removed by using an EW15 with an "O" in the other coverage field and the card issue location "MEDS". The correct OHC code can be added by using a second EW15 with the correct OHC code and a card issue location of "LOGS" or an online EW30 with the new OHC code. When two EW15s are used, the EW15 with the OHC code "O" must be done first. The card sent out will then show the correct OHC code.

   Both transactions should be done on the same day because only card print transactions are forwarded to the fiscal intermediary. By doing both transactions on the same day, the Medi-Cal card will show the correct other coverage code and the fiscal intermediary will have the correct OHC information for processing claims.

   If for some reason the county is unable to do both transactions on the same day, a second EW15 must be done the following day. The card issue location for the second EW15 should be "LOGS". In this instance, the Medi-Cal card will show an other coverage code of "N", but the fiscal intermediary will have the correct OHC information for processing claims.

If the correction needs to be made for future card issuance only, (1) two online EW30 transactions can be used, the first with an "0" and the second with the correct other coverage code, or (2) two batch EW20 or EW30 transactions can be used if the county system can send a later Julian date on the second transaction. Both transactions can be sent in the same daily batch tape.

FOR SSI/SSP BENEFICIARIES:

Remove the incorrect code by using an EW55 with an "0" in the OHC field and the card issue location "LOGS". If the card is to be mailed, a second EW55 should be done the same day with the correct OHC code and card issue location "MEDS". If the card is to be printed in the county, a second EW55 should be done the following day with the correct OHC code and card issue location designating the county printer

2. IF THE CLIENT NEEDS A CARD IMMEDIATELY:

FOR NON-SSI/SSP BENEFICIARIES:

Counties should do an EW15 with an "0" and print a card on the county printer. A follow-up EW15 with card issue location of "LOGS" or an EW30 with the new other coverage information must be done on the same day so that the correct other coverage code can be passed to the fiscal intermediary.

If the county is unable to do an EW30 on the same day as the EW15, a second EW15 must be done the following day. The card issue location for the second EW15 should be "LOGS". This will ensure that the fiscal intermediary will have the correct other coverage information for processing claims.

FOR SSI/SSP BENEFICIARIES:

Counties should do an EW55 with an "0" and print a card on the county printer. A follow-up EW55 with the new other coverage information must be done with a card issue location "LOGS". The EW55 with the OHC code "0" must always be done first.

<u>When will counties be required to input cost avoidance codes for new recipients and at redetermination</u>?

The Department will issue formal procedures informing the County Welfare Departments when they must begin to determine if a cost avoidance treatment of other health coverage is appropriate. Until such time as these procedures are received, the counties are to continue to use the existing OHC codes with the following exceptions: at redetermination, counties must code dependents of parents identified in tape matches if the dependents are also covered by the same health insurance policy.

When is it necessary to complete HRB 2As?

The State will use the HRB 2A for retroactive billing, and to evaluate dependents' coverage. In order to accomplish this, counties must send HRB 2As in the following instances:

1. For dependents who are covered under a parent's policy that has been cost avoidance coded, counties must mark "CA/Dep" in the upper right hand corner of the HRB 2A.

2. If there is retroactive coverage for a newly coded cost avoidance client that was available prior to July 1, 1987, and the OHC has not been previously reported, counties must mark "CA/Retro" in the upper right hand corner.

If you have any questions regarding MEDS input, contact your MEDS liaison. Any other questions should be directed to the Health Insurance Unit, Paula Marty, at (916) 739-3274.

Sincerely,

Original signed by

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Attachment

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH SERVICES

OTHER HEALTH COVERAGE INDICATOR CHANGE REPORT

PROGRAM: RCV139D
REPORT NBR: HR-RCV139D-R007

PAGE NUMBER: Z,ZZ9
RUN DATE: MM/DD/YY

MEDI-CAL BENEFICIARIES WITH PRIVATE FULL COVERAGE HEALTH INSURANCE
SAN DIEGO COUNTY

DISTRICT OFFICE : XXX
EW NO : XXXX

BENEFICIARY NAME	SSAN (MEDS-ID)	COUNTY-ID	BIRTHDATE	OHC CODE	CASE NAME
FIRSTNAMEX X LASTNAMEXXXXXXX	233 21 4444	37 35 4567890 1 23	04 24 086	B	Lastname, Firs

DATE: 05/22/07

REVISION:

SYSTEM/PROJECT: RCV2007

DEPARTMENT OF HEALTH SERVICES - DATA SYSTEMS BRANCH

R E C O R D L A Y O U T

FILE NAME: ONC INDICATOR CHANGE

ORIGINATOR: CISNEROS

REVIEWER:

SOURCE PROGRAM: RCV109

001-009	010-023	024-086
SSN	County ID: Co, Aid, Case No, FSU, Pers No	NAME: LAST NAME, FIRST NAME

051-053	054-059	060-061	062-064	065-068	069-086
NAME: cont'd, INITIAL	DOB: MM, DD, CYY	DISCOVE	DD	EH NO	

MODE: BINARY - B
PACKED - P

LABELS: STANDARD [X]
NON-STANDARD [ ]

RECORD FORMAT: FIXED - F [X]
VARIABLE-V [ ]

RECORD LENGTH: 86

RECORDS PER BLOCK: 0000

BLOCK SIZE: 00000

PROGRAM: RCV109

USE: INPUT
OUTPUT X