August 20, 2001

TO:     All County Welfare Directors
       All County Administrative Officers
       All County Medi-Cal Program Specialists/Liaisons
       All County Health Executives
       All County Mental Health Directors

Letter No.: 01-46

250 PERCENT WORKING DISABLED PROGRAM UPDATE

Ref.:  All County Welfare Directors Letter (ACWDL) Nos. 00-16, 00-51, 01-14,
       and 01-26

This letter is to update the counties on the status of the new estimated implementation
date of the 250 Percent Working Disabled (WD) automated billing and payment system
(ABPS) and provides a description of how the system is to work. This letter also
provides instructions to add 250 Percent WD information to the Disability Transmittal
form.

In the ACWDL 01-14, the estimated implementation date for the ABPS was to be
August 2001. The estimated implementation date is now 2002 and will be implemented
in phases. The ABPS monthly billing statements will be generated beginning
March 2002. The tracking of premium payments and discontinuing eligibility due to non-
payment of premiums will be later in 2002. Other ACWDLs will be issued as the
different ABPS phases are implemented.

The ABPS, when implemented will:

• track the premium payments on Medi-Cal Eligibility Data System (MEDS);
• send monthly invoices to the 250 Percent WD individuals reported eligible by the
  county;
• discontinue 250 Percent WD individuals who have failed to pay full premiums for two
  consecutive months;
• issue a worker alert to inform the county worker of the individual's discontinuance
  from the 250 Percent WD program due to the nonpayment of premiums.
When a premium payment is received by the Department of Health Services (Department) and applied to the individual’s account, a certification date is added to their MEDS record. This certification date will appear as it does when a share of cost (SOC) is met for SOC individuals. If the certification code does not appear on MEDS for two-consecutive months, the individual will be discontinued from the 250 Percent WD program due to non-payment of premiums. The Department will send these individuals a discontinuance notice (please see the enclosed Medi-Cal Notice of Action, MC 338-F) and will notify the county worker of this discontinuance with a worker alert. Counties are to conduct an immediate redetermination as to whether the individual is eligible for any other Medi-Cal program.

The monthly invoice sent to the 250 Percent WD individuals is similar to a billing statement. The invoice will inform individuals of:

- amounts credited to their account due to a premium adjustment;
- premium amounts not paid;
- the monthly premium amounts;
- the total premium amount due; and
- mailing instructions for the payment of premiums.

Until the ABPS in fully operational, the Department is manually processing non-payment of premium notices and mailing them to the beneficiaries. The Department is also identifying beneficiaries that have not paid premiums for two or more months and will be notifying the 250 Percent WD coordinators by E-Mail or telephone to request that the county:

- discontinue individuals from the program due to non-payment of premiums;
- send a discontinuance notice of action; and
- conduct redeterminations for any other Medi-Cal program.

Until the ABPS is implemented, please continue to supply envelopes to the 250 Percent WD individuals in which to mail their premiums. To order an additional supply of envelopes, call (916) 322-0019.
When/if preparing a disability packet for the 250 WD Percent individual to be sent to the Disability and Adult Programs Division, identify the 250 Percent WD cases on the Disability Transmittal form (MC 221) by:

- checking the “Other” box in number 8; and
- entering “250 Percent WD program” in number 10.

If you have any questions regarding this letter or the 250 Percent WD program, please call Ms. Vicki Partington of my staff at (916) 654-5909 or E-Mail Vparting@dhs.ca.gov.

Sincerely,

ORIGINAL SIGNED BY

Shar Schroepfer, Chief
Medi-Cal Eligibility Branch

Enclosures
MEDICAL
NOTICE OF ACTION
DISCONTINUANCE FOR FAILURE TO PAY
FULL PREMIUMS IN THE 250 PERCENT
WORKING DISABLED PROGRAM

Notice date: _________________________
Case number: _________________________
Worker name: _________________________
District: _________________________
Worker number: _________________________
Worker telephone: _________________________
Worker hours: _________________________
Discontinuance from the 250 Percent Working Disabled program for: _________________________
(names)

We have reviewed all information about your payment of premiums in the 250 Percent Working Disabled program and have determined that you have not paid the required premiums for two months.

Your enrollment in the 250 Percent Working Disabled program will be discontinued, effective the last day of _________________________.

If you have any questions about your premium payments, you may call the Department of Health Services, Third Party Liability Branch, at (916) 324-4162.

If you are eligible for Medicare, this means that _________________________ (month) is the last month the State will pay your premium for Part B Medicare supplementary insurance coverage. You will receive a written notice from the Social Security Administration, or you may call your Social Security district office if you have questions about your Medicare status.

This discontinuance action does not affect your eligibility for any other Medi-Cal program. You will receive another notice from your county Department of Social Services concerning any other Medi-Cal coverage for which you may be eligible. If you have any questions about such eligibility, please write or telephone your county eligibility worker.

DO NOT THROW YOUR PLASTIC ID CARD AWAY. You can use it again if you become eligible for Medi-Cal in the future.

This action is required by All County Welfare Directors’ Letter 00-16.
County Welfare Department Address

Oakland State Programs Branch
P.O. Box 23645
Oakland, CA 94623-9945

5. Date applied
Month - Day - Year

6. List retro month(s)

7. Mailing address

8. Type of referral (check appropriate box(es))
- Initial referral
- Redetermination
- Reevaluation
- Pickle-blind
- Reexamination
- IHSS
- SGA IHSS
- SGA-disabled
- CAPI
- Retro-onset
- Limited referral
- Other—explain (item 10)

9. Is applicant in a hospital? □ Yes □ No
Name of hospital:

10. County worker comment(s) (If more space is needed, attach a separate sheet.) □ See attached sheet (e.g., DHS 7045)

11. File reviewed and approved for transmittal

12. Date sent
Month - Day - Year

13. □ See attached DAPD Documents (This is NOT a certification for in-home supportive services.)
Comment(s) or SP-DAPD Presumptive Disability decision

14. Analyst

15. Date

16. Team manager

17. Date

DISABILITY DETERMINATION AND TRANSMITTAL

SEE BACK OF COPY 4 □ Oakland □ Los Angeles