

DEPARTMENT OF HEALTH SERVICES

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August 7, 1981

To: All County Welfare Directors

Letter No. 81-35

PROVISIONS OF ASSEMBLY BILL 251 (AB 251)

This letter is to provide you with general information regarding the Medi-Cal provisions of AB 251. The changes are discussed separately below. The detail of information included for a given item varies depending upon:

1. The item's impact on either county welfare departments or Medi-Cal beneficiaries;
2. The amount of information currently known by the Department regarding proposed plans for implementation; and
3. Whether the Department plans to transmit details shortly via a separate letter.

Some items such as hospital reimbursement rates, deletion of Medi-Cal coverage for persons receiving Aid to the Potentially Self-Supporting Blind program (the Cash program repealed by Senate Bill 633 (SB 633)), and other items are not discussed in this letter.

Background

AB 251 is an urgency bill; therefore, it became effective upon signing by the Governor. However, certain provisions are not effective until the process of seeking waivers of conflicting federal law is completed. This is discussed below in more detail.

The legislation provides that the Department shall adopt emergency regulations to implement the provisions contained therein, and that the regulations are not subject to review by the Office of Administrative Law until they have been in effect for 120 days.

Additionally, since some provisions will require federal waivers to implement the change across the board for all affected Medi-Cal beneficiaries, the legislation provides that such provisions will not be implemented for any Medi-Cal beneficiary until it is known whether the federal waiver request has been approved or rejected. This "safety valve" is designed to alleviate the administrative time/cost associated with implementing a change for one group at one time and another group at a later time, or implementing a change across the board, and then "undoing" that change for a specified group if a federal waiver is not obtained.

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The Department is working to secure adequate funding for county costs of implementing the provisions of AB 251.

The eligibility-related provisions discussed below are:

1. Reduction of Medi-Cal Maintenance Need level from 133 1/3 percent to 115 percent of the Aid to Families with Dependent Children (AFDC) payment level (subject to federal waiver).
2. Reduction of "AFDC 4-months continuing" automatic Medi-Cal coverage to "AFDC 3-months continuing" coverage (subject to federal waiver).
3. Change of the budgeting and share-of-cost-computation period from monthly to quarterly, for all Medi-Cal-only persons except long-term care (LTC) patients (subject to federal waiver).
4. Elimination of the "\$20 any-income" deductions and other income deductions, when share of cost for an MFBU which includes an LTC patient is computed.
5. Recovery of Medi-Cal costs from the estate of certain deceased aged Medi-Cal beneficiaries (including former Supplemental Security Income/State Supplementary Payment (SSI/SSP) recipients).
6. Clarification that Social Security Administration (SSA) is responsible for Medi-Cal eligibility determinations for SSI/SSP recipients.
7. Requirement for legislative audit of Medi-Cal-only eligibility process in one or more counties, for report to Legislature assessing the proposal that the State assume that process.
8. Expanded county role in collection of private health coverage data from Medi-Cal-only beneficiaries and AFDC recipients.
9. County collection of beneficiary caused Medi-Cal overpayments, on a cost-plus-incentive-payment basis.
10. Verification/identification of earnings data of Medi-Cal-only beneficiaries through the earnings clearance process currently used for AFDC recipients.
11. Elimination of the requirement that a proof-of-eligibility label be attached to medical provider claims submitted for payment.
12. Study of the feasibility of an automated patient eligibility status inquiry/answer system for Medi-Cal providers.

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13. Installation of beneficiary copayment fees for certain services by most Medi-Cal patients at the option of the provider.
14. Expanded eligibility quality control effort by state staff.
15. Provision of photo identification cards to Medi-Cal beneficiaries.

Explanations are as follows:

1. Medi-Cal Maintenance Need Reduction

Description: AB 251 lowers the maintenance need levels for Medi-Cal Family Budget Units (MFBUs), consisting of two or more persons from 133 1/3 percent of the AFDC payment level to 115 percent of the AFDC payment level. It also changes the manner in which the maintenance need level for single individuals is computed by tying it to the maintenance need level for two persons rather than the AFDC Minimum Basic Standard of Adequate Care (MBSAC) level for two persons. However, the maintenance need formula change for one is a technical change only, and does not change the relative distance between one and two persons in maintenance needs. The additional increase per person for families consisting of 11 or more persons is still equal to the MBSAC amount.

Impact: Since a federal waiver is required to reduce the maintenance need level for two persons to an amount below 133 1/3 percent of the AFDC payment level, none of the levels will change until we know the outcome of the waiver request (anticipated by approximately January 1982). If a waiver is obtained, all of the levels will be reduced after the first of the year. If the waiver request is denied, the levels for MFBUs containing three or more persons will be reduced after the first of the year.

The change in the method by which the level for single individuals is calculated was included to protect the current relationship between the level for one person and the level for two persons. Since SB 633 reduced the MBSAC down to the AFDC payment level, the maintenance need level for one person would have decreased if this statute change had not been made.

SB 633 also reduced the additional MBSAC increase per person for families consisting of 11 or more from the anticipated ten dollars to nine dollars. This means the additional amount per person issued in County Welfare Directors Letter No. 81-23 is incorrect.

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The July 1981 increased levels will be issued in the procedures portion of the Medi-Cal Eligibility Manual shortly. Instructions regarding implementation of this minor change will be issued at the same time.

2. Four-Month-Continuing Eligibility

Description: Currently, families discontinued from AFDC cash solely due to increased earnings or hours of employment receive four months continued no-cost Medi-Cal eligibility. AB 251 reduces the continued coverage from four months to three months.

Impact: Since a federal waiver is required, it will probably be approximately January 1982 before we know whether this provision can be implemented.

3. Share-of-Cost Period

Description: Except for persons in LTC, the share-of-cost period will change from monthly to quarterly.

Impact: You will receive a separate letter providing details and requesting information on the impact of implementation on your county's operations. A federal waiver prior to implementation is required.

4. Share-of-Cost Determinations for MFBUs Which Include a Person in LTC.

You have already received a detailed letter describing this provision and authorizing immediate implementation. Income deductions will now be added in to the total share of cost.

5. Claim Against the Estate of Deceased Persons

Description: The Department can claim against the estate of an aged decedent an amount equal to the amount of medical expenses paid by Medi-Cal funds providing the decedent has no spouse, minor dependents, or other dependents who are blind or permanently and totally disabled within the meaning of the Social Security Act.

Impact: Department of Health Services (DHS), Health Recovery Section, will be responsible for the collection of such claims.

6. Agency Responsible for the Determination of Medi-Cal Eligibility

Description: Statute has been modified to incorporate our practice of contracting with SSA to determine Medi-Cal eligibility for SSI/SSP recipients. Statute now also specifies that counties are responsible for determining eligibility when SSI/SSP eligibility is lost.

Impact: None at present. However, we are currently involved in litigation, Ramos vs. Myers which will impact Medi-Cal eligibility for terminated SSI/SSP recipients. Information on the results of that litigation and its impact on state and county Medi-Cal operations will be provided as it becomes known.

7. Study on State Control of Medi-Cal Eligibility

Description: The Joint Legislative Audit Committee (i.e., the State Auditor-General) will be conducting an audit of one or more counties and report to the Legislature recommendations for state control of the eligibility process.

Impact: Unknown at this time. Since this project is to be done by legislative staff, the extent to which this Department will have input to the study, or review of the results, or a coordinating role in the audit, is also unknown.

8. Collection of Information Regarding Other Health Coverage

Description: County staff will complete a form to collect detailed information regarding private health insurance owned by Medi-Cal applicants/beneficiaries. This applies to Medi-Cal-only beneficiaries, to AFDC recipients, and to other Medi-Cal beneficiaries who may be served by other county agencies.

Impact: Additional information must be collected by MAO and AFDC eligibility workers. This additional information will assist Recovery Section of DHS in its insurance payment collection efforts. A pilot study conducted in three counties demonstrated a significant increase in monies collected under this system. You will be provided with more details prior to implementation.

9. Beneficiary Overpayment Collection

Description: The Department can enter into agreements with counties whereby counties will be responsible for the overpayment collection effort. The counties will receive an incentive amount equal to ten percent of the amount recovered after costs of recovery have been deducted.

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The definition of willful failure currently in regulations will be revised. The act of not reporting a change, once advised that changes should be reported, will constitute willful failure under the new definition. When potential overpayments are identified by counties, the county will obtain from the Department's fiscal intermediary a services history profile so the amount of the actual overpayment can be calculated and client reimbursement requested by the county.

10. Earnings Clearance System

Description: An earnings clearance system must be established for Medi-Cal-only cases.

Impact: Prior to full implementation, we plan to test the effectiveness of such a system in the Medi-Cal program. A random sample of Medi-Cal-only eligibles will be used for testing purposes. You will be kept informed and your input will be solicited as plans develop.

11. Photo Identification

Description: The Department must provide an identification card to all Medi-Cal beneficiaries, including public assistance recipients, who do not possess a California driver's license or an identification card issued by the Department of Motor Vehicles. The providers have the responsibility to verify identification before accepting a Medi-Cal card as payment.

Impact: Implementation plans have not been developed. You will be provided with details at a later date.

12. Label Relief/Labelless Billing

Description: Payment of a claim cannot be denied solely because a Medi-Cal label or photocopy of the card is not affixed to the bill. The requirement to provide label relief to county contract hospitals has been repealed. Follow-up legislation has been proposed to clarify that AB 251 does not alter the current access to patient eligibility information that is available to county hospitals and other government health facilities. There is also litigation currently on this issue.

Impact: County generation of replacement Medi-Cal identification cards, for transmission directly to county hospitals, etc., should decrease. This decrease will occur in those counties whose medical facilities can inquire directly, as to the Medi-Cal status of patients. You will be provided with more information on the interaction of AB 251, the litigation, and following legislation, as it becomes available.

13. Provider On-line Inquiry System for Eligibility Information

Description: A feasibility study of an automated eligibility verification system for providers must be completed and the results reported to the Legislature by May 1982.

Impact: Unknown at this time.

14. Copayment

Description: Most Medi-Cal beneficiaries are required to make copayments; for three types of services: (1) typical outpatient services -- physicians, chiropractic, optometric, therapy, etc.; (2) drug services; (3) nonemergency services received in an emergency room. Copay for the first two types of service is one dollar per service; copay for the third type is five dollars per service. Patients 12-years or under are exempt from any copayment; persons 65 or over are exempt from drug copayment; and certain other individuals are exempt from one type of copayment or another. The copayment collected by providers is an amount in addition to the normal Medi-Cal reimbursement received for a particular service. Providers may either collect and retain the copayment fee or they may waive the copayment requirement.

Impact: Current federal regulations severely restrict the application of copayment requirements to many Medi-Cal eligibles. As a result, a federal waiver will be sought. No implementation will occur until we know whether or not the waiver has been approved. If the waiver request is granted, no additional eligibility work will ensue. If the waiver is approved in limited form, additional effort on the part of eligibility staff may be necessary to identify those Medi-Cal beneficiaries to whom total copay can apply as opposed to those beneficiaries to whom only a much more limited version of copay is applicable. This will depend on the nature and extent of the waiver(s) received.

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15. Expanded Quality Control Effort

Description: The State Quality Control effort on Medi-Cal eligibility will be expanded to incorporate medically indigent (MI) adult cases and to provide for a statistically valid sample size for all 58 counties.

Impact: Once details are known, you will be provided with more information. Obviously, more cases per county will be reviewed. Since error rates for individual counties can be developed, more detailed county corrective action planning can occur, and specialized corrective action for MI adults can be developed as needed on either a county or statewide basis.

In addition to the separate correspondence on specific provisions as noted above, we will also provide information on other provisions as the information becomes known, if it has county impact or is of interest to counties. Also, we will be working with the Medical Care Committee of the California Welfare Directors Association on specifics of implementing these provisions, so as to obtain as smooth and efficient transition into the new provisions as possible.

If there are any questions regarding this letter, please contact the Medi-Cal program consultant for your county.

Sincerely,

Original signed by

David Mitchell for
Madalyn M. Martinez, Chief
Medi-Cal Eligibility Branch

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants