STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, *Governor*

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 657-2941

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

MEDI-CAL
NOTICE OF ACTION
DISCONTINUANCE FOR FAILURE TO PAY FULL PREMIUMS IN THE 250 PERCENT WORKING DISABLED PROGRAM

(COUNTY STAMP)

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 _____ is the last month the
(month)
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.

ENCLOSURE

State of California—Health and Human Services Agency

Department of Health Services

County Welfare Department Address

PLEASE PRINT

Retain Copy 4
(Send copies 1, 2, and 3 to DAPD)
DO NOT MAIL TO APPLICANT

County number | Aid code | Case number

DAPD Address

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

1. Applicant name (first) (middle name) (last)

2. Social Security number ☐ Pending ☐ None

3. Date of birth Month Day Year

4. Sex ☐ Male ☐ Female

5. Date applied Month Day Year

6. List retro month(s) Month/Year Month/Year Month/Year

7. Mailing address

8. Type of referral (check appropriate box(es))

- ☐ Initial referral
- ☐ Redetermination
- ☐ Reevaluation
- ☐ Pickle-blind
- ☐ Reexamination
- ☐ IHSS
- ☐ SGA IHSS
- ☐ SGA-disabled
- ☐ CAPI
- ☐ Resubmitted packet
- ☐ Retro-onset
- ☐ Limited referral
- ☐ Other—explain (item 10)

Telephone number: (area code)

9. Is applicant in a hospital? ☐ Yes ☐ No

Name of hospital:

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

☐ (MC 179) 90-Day Status Letter attached ☐ Presumptive Disability approved

11. File reviewed and approved for transmittal

Worker number | Print worker name

Telephone number (area code) | FAX number (area code) | 12. Date sent Month Day Year

DAPD USE ONLY

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

MC 221 OAK (1/00)