

Medi-Cal Program Guide (MPG) Letter #731

October 17, 2011

Subject UPDATE TO THE ELIGIBILITY REDETERMINATION PROCESS WHEN BENEFICIARIES ARE TERMINATED FROM THE FEDERAL BREAST AND CERVICAL CANCER TREATMENT PROGRAM (BCCTP)

Effective Date July 25, 2011

Reference ACWDL 11-29

Purpose The purpose of this letter is to inform staff of changes to the redetermination process when a beneficiary is no longer eligible for federal Medi-Cal benefits under the BCCTP.

Background The Department of Health Care Services (DHCS) has the statutory requirement to perform eligibility determinations for BCCTP applicants and beneficiaries under BCCTP rules. When a BCCTP beneficiary no longer meets the federal BCCTP requirements and is scheduled to be discontinued from BCCTP Medi-Cal, a SB 87 eligibility review under other Medi-Cal programs must be completed before BCCTP Medi-Cal benefits can be discontinued. DHCS does not have the authority to make redeterminations of eligibility for any other Medi-Cal program. Therefore, when DHCS determines that a woman is no longer eligible for Medi-Cal under the federal BCCTP rules, DHCS staff will discontinue her from BCCTP Medi-Cal and place her in an interim Medi-Cal aid code until the county completes the eligibility determination.

Change DHCS has established four new interim BCCTP aid codes and former BCCTP women will remain in the appropriate interim aid code until the county makes an eligibility determination. These new aid codes will facilitate a seamless eligibility determination process for county and State-funded BCCTP staff.

Information on the scope of coverage and descriptions of the four aid codes are detailed in [MPG Article 4, Section 16.05I](#)

Required Action

During the redetermination period, if the woman being discontinued from federal BCCTP Medi-Cal appears to be eligible for State-funded BCCTP coverage, DHCS staff will concurrently determine her eligibility under the State-funded BCCTP pending the outcome of the county worker's Medi-Cal eligibility review.

Automation Impact

The state mandates that counties track those beneficiaries discontinued from federal Medi-Cal benefits under the BCCTP program. The counties will receive an "Exception Eligibles" (EE) tracking report on a monthly basis. The EE report is a tool for ensuring the interim BCCTP cases have a completed county eligibility determination. The EE report will show the number of months the beneficiaries have been in a BCCTP interim Medi-Cal aid code pending county redetermination.

In order to assist FRCs in tracking and monitoring BCCTP referrals, automation staff has generated the [Exception Eligible Tracking Report](#). The report will be uploaded to SharePoint monthly.

EXCEPTION ELIGIBLES TRACKING REPORT DEFINITION

TITLE	DEFINITION	AID CODE	MEDS ALERT(S)
SB87-BCCTP	Breast and Cervical Cancer Treatment Program	0W, 0X, 0Y, 0L	9548

Forms Impact

No impact.

ACCESS Impact

No impact.

Imaging Impact

No impact.

Quality Assurance Impact

No impact.

Summary of Change

The table below shows the changes made in the Medi-Cal Program Guide.

MPG Section	Changes
Article 4, Section 16.05	<ul style="list-style-type: none">• Info mapped the Article• Updated the Redetermination procedures for discontinued BCCTP beneficiaries to include the four new interim Aid Codes• Added an example illustrating a seamless eligibility determination process for county and State-funded BCCTP staff.

**Manager
Approval**



Sylvia Melena, Assistant Deputy Director
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Strategic Planning and Operational Support Division

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Article 4 Section 16 – Inter/Intra Program Transfer

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4.16.01 Inter/Intra Program Transfer

A. Introduction

A person or family discontinued from cash-based Medi-Cal (except SSI/SSP) is entitled to evaluation for Medi-Cal only benefits without having to make a new application. This section provides instructions for processing inter/intra program transfers for persons who lose eligibility to cash-based Medi-Cal resulting from a discontinuance of CalWORKs, RCA/CHEP or IHSS. Ramos vs. Myers procedures for people discontinued from SSI/SSP are also included in this section.

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B. Definitions

Intra-program Transfer

- A transfer occurs when a person's or family's eligibility status changes from one category to another aid category and the first digit of the aid code remains the same. Example 30 to 37

Inter-program Transfer

- A transfer occurs when a person's or family's eligibility status changes from one aid category to another aid category and the first digit of the aid code changes. Example 30 to 64.

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4.16.02 Inter/Intra Program Referral Procedures RCA/CHEP

A. RCA/CHEP Referrals

Persons discontinued from RCA/CHEP (aid types 01 and 08) will be referred for a Medi-Cal Only eligibility determination when the beneficiary has requested continuing Medi-Cal within five calendar days from receipt of the RCA/CHEP discontinuance notice.

B. Inter/Intra Program Transfer Not Required

Beneficiaries are not to be referred for an inter/intra program transfer determination when the RCA/CHEP case has been discontinued for any of the following reasons:

- Loss of California residency;
- A move with loss of contact and where County mail sent to the beneficiary has been returned;
- Death;
- Inter-county transfer;
- Failure to provide information necessary to meet RCA/CHEP or IHSS requirements when the same requirements exist for all Medi-Cal only programs for which the person may be eligible; OR
- Failure to complete the renewal process.

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C. Inter/Intra Program Referral Process

Upon receipt of the inter/intra program transfer request, the worker shall:

- Determine if there is sufficient information in the RCA/CHEP case to make eligibility determination. When there is sufficient information then the worker shall grant the case. The RCA/CHEP renewal date will determine the next Medi-Cal redetermination date; or
 - Determine if there is insufficient information in the RCA/CHEP case to make an eligibility determination. When there is insufficient information the worker shall perform the "Application Registration" process and generate CSF 77. If the beneficiary doesn't respond within ten days, the case will be denied. The worker shall generate a denial notice of the inter/intra program transfer because of failure to provide information needed to make a Medi-Cal eligibility determination.
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D. Eligibility Require- ments,

The beneficiary is not required to complete an application form SAWS1 to be granted an inter/intra program transfer. A new Statement of Facts (SOF) will not be requested if the existing SOF is less than a year old.

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**RCA/CHEP
Referrals**

The RCA/CHEP renewal date will determine the next Medi-Cal redetermination date. If the RCA/CHEP renewal is due in the month of or month following the inter/intra program request, the worker shall complete the Medi-Cal renewal following the procedures in [Article 4, Section 15](#).

If the worker determines that the beneficiary will have a share of cost, this is not considered an adverse action and is not subject to the ten-day notice requirement.

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4.16.03 Inter/Intra Program Referral Procedures CalWORKs

A. CalWORKs Discontin- uance

SB 87 mandates continued Section 1931(b) Medi-Cal Only eligibility for discontinued CalWORKs beneficiaries except in circumstances that indicate Medi-Cal ineligibility (e.g., death, out-of-state residence). When CalWORKs is approved, Medi-Cal eligibility under Section 1931(b) is also approved. Discontinued CalWORKs recipients must continue to receive Medi-Cal benefits under Section 1931(b) or be evaluated for other Medi-Cal programs.

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B. CalWORKs Discontin- uance Reasons that Do Not Affect Section 1931 (b) Eligibility

CalWORKs recipients who are discontinued for reasons that do not affect Section 1931(b) eligibility shall continue to receive Section 1931(b) benefits without the worker having to complete an eligibility determination. Discontinuance reasons that do not affect Section 1931(b) include, but are not limited to:

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- non-cooperation with Welfare-to-Work;
- expiration of CalWORKs time limits;
- failure to provide a CalWORKs income report (this does not include instances when a change is reported that affects Medi-Cal eligibility, but for which required verification is not provided);
- immunization requirement;
- school attendance requirement;
- intentional program violations; or
- non-cooperation with statewide Fingerprinting Imaging System.

The redetermination date for the Section 1931(b)-only case remains unchanged from the CalWORKs renewal date.

C. *Ex-Parte* Review Required for Certain CalWORKs Discontin- uances

CalWORKs cases that close for a reason that may affect Medi-Cal eligibility are subject to an *ex parte* review as described in [Article 4.07.12](#). The worker shall convert the case to AC38 during the *ex-parte* evaluation. See [4.16.3H](#) below. This includes a parent in a two-parent CalWORKs family who leaves the home. A discontinuance of CalWORKs benefits does not necessarily constitute automatic discontinuance from the Section 1931(b) Medi-Cal Program, unless there is clear evidence that eligibility for ongoing Medi-Cal benefits is lost.

Do not request information or verification that:

- has been previously provided within the last twelve months;
- is not subject to change (i.e., identification, social security number, etc.);

- is available for verification in CalWIN; or
- is not necessary for completing a Medi-Cal determination.

See [Appendix B](#) for a chart to assist the worker in determining when an *ex parte* review is required.

**D.
CalWORKs
Denials
(Rollovers)
and
Diversion
Cases**

All CalWORKs denials (including failure to provide) must be evaluated for Medi-Cal eligibility. The worker shall use the *ex parte* process as required as part of this evaluation.

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**E.
Foster Care**

Foster care cases transitioning into Section 1931(b) Medi-Cal are treated the same as CalWORKs cases. Form MC 210 RV is not required until the annual Medi-Cal redetermination. It is critical that children discontinued from FC continue to receive zero SOC Medi-Cal benefits through the next renewal.

**F.
No *Ex Parte*
Review and
No 1931(b)
Required**

The worker is not required to conduct an *ex parte* review and shall not convert a person to 1931(b) when the CalWORKs eligibility has closed for one of the following reasons:

- loss of California residency;
- the beneficiary submits a written request to discontinue Medi-Cal benefits;
- incarceration;
- death of beneficiary; or
- the individual is transitioning to another PA program that provides Medi-Cal (Foster Care, SSI, IHSS AAP, etc.).

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The discontinuance reason which requires no further review of Medi-Cal eligibility must be included in case comments. If a discrepancy is discovered when reviewing the case record, the workers shall follow-up and take appropriate action. For example, if the worker discovers that the case should have closed for other reasons that require an *ex parte* review, the worker shall complete the *ex parte* and determine if conversion to ongoing Medi-Cal is appropriate.

Note: Other family members discontinued from CalWORKs may be entitled to an *ex parte* review and conversion Medi-Cal only benefits. Therefore, each individual's reason for CalWORKs discontinuance must be reviewed.

**G.
Failure to
Complete
the
CalWORKs
Annual
Renewal**

CalWORKs discontinuances due to failure to complete the annual renewal will convert to AC 38; these cases must have a Medi-Cal annual redetermination completed. This would also apply if the CalWORKs annual renewal were due while the 1931(b) case is being processed. The MC 210 RV is to be used for the purpose of completing the annual redetermination. Discontinue the 1931(b) benefits with timely notice if the beneficiary fails to complete the MC 210 RV within the required timeframe. If the redetermination is completed timely and Medi-Cal eligibility is established, certify the case for 12 months from the signature date on the MC 210 RV.

Note: When the MC 210 is used in the above situation, the worker must obtain MC 13s and, if applicable, Principal Wage Earner (PWE) status must be documented in the case file.

Children in the Medi-Cal Family Budget Unit (MFBU) will not be eligible to the Continuous Eligibility for Children (CEC) Program if ineligibility to Medi-Cal is determined upon processing the annual redetermination. Since an annual redetermination is due, the children's 12 months of zero share of cost Medi-Cal would have expired.

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**H. AC 38
Process**

When converting AC 38 cases to ongoing Medi-Cal, the worker shall first review any verification/information available in CalWIN that is essential to determining ongoing Medi-Cal eligibility. (Following *ex parte* guidelines outlined in [Article 4.07.12](#))

In any of the situations below that involve failure to provide verification, the worker shall request the information using the procedures described in [Article 4.07.10](#).

**I.
Loss of
Contact/
Whereabouts
Unknown**

When a CalWORKs case is discontinued for loss of contact/whereabouts unknown follow the procedures for requests for information outlined in [Article 4.07.10](#). Send the request for verification to the last known address of the beneficiary and take the following action as appropriate:

- If return mail is received, discontinue the case.
- If partial information is received, send a notice to discontinue the parents and evaluate the children for CEC.
- If all the requested information is received, evaluate the household members for continuing Medi-Cal.
- If the evaluation indicates ineligibility or SOC Medi-Cal, take

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appropriate action on the parents and evaluate the children for CEC.

J. Only Eligible Child Leaves the Home Other family members must be evaluated for all other possible eligibility to Medi-Cal when the only eligible child leaves the home. The worker shall convert the case to AC38 during the *ex parte* evaluation. Children removed from the home, as part of the Family Reunification (FR) Program, may not link FR parents to 1931(b) or Medically Needy Medi-Cal. See [Article 5.04](#) for instructions on how to treat a person who claims disability.

K. Failure to Provide Situations The worker shall obtain information/verifications necessary for an accurate eligibility determination. The worker shall convert the case to AC38 during the *ex-parte* evaluation. Follow the instructions outlined in Article [4.07.12](#). If a CalWORKs case closes for failure to provide, any children discontinued from the CalWORKs case under nineteen years of age may be eligible to the CEC Program.

L. Eighteen-year-old Completes School and is No Longer Eligible to CalWORKs A child in this situation is entitled to 1931(b) benefits and an *ex parte* review of the case record. The child must be evaluated for eligibility to continuing Medi-Cal. If eligibility to a zero SOC program cannot be established, the child must be evaluated for CEC, since the child is still under nineteen years of age.

M. AC 38 Discontinuance AC 38 cases must be discontinued for any of the following reasons:

- Death
- Failure to complete the statement of facts or provide requested verification
- When one or more persons are being discontinued from the case
- No linkage or excess resources
- Loss of residence
- Discontinuance at beneficiary's request
- Whereabouts unknown.

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4.16.04 Craig V Bonta Referral Procedures

A. Craig

Based on the 2003 Craig v Bonta (Craig) court order, new procedures were established for continuing the Medi-Cal benefits for certain categories of SSI/SSP individuals discontinued from SSI effective 7/1/02. The Craig procedures replaced the previous Ramos v Myers procedures.

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The following are changes as a result of Court's decision in the Craig lawsuit:

Beneficiaries discontinued from SSI are not required to complete a statement of facts or request Medi-Cal to be evaluated for ongoing Medi-Cal benefits.

Craig cases shall undergo an evaluation following SB 87 guidelines. This includes beneficiaries who were discontinued from SSI due to loss of contact.

For Craig cases, information received over the telephone may be used to establish ongoing eligibility. However, income and property must be verified in writing.

The following items are **not** needed to establish ongoing Medi-Cal eligibility for Craig beneficiaries:

- MC210
- MC210RV
- SAWS 1
- MC13
- Verification of identity
- Verification of residency.

DHCS will issue monthly Craig Exception Eligible reports. Beneficiaries remain on this list until an eligibility determination is made and the information is reported to MEDS.

If a Craig individual is in Long-Term Care (LTC), the worker shall contact the facility and ask if the individual is competent. If the facility indicates that the individual is not competent, the worker must ask if he/she has someone to represent him/her. If the individual does not have a representative, either through the facility or through a relative, friend, etc., a referral to the Public Guardian must be made.

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A new abbreviated referral form HHS 14-78, [Appendix D](#), has been developed to refer to the Public Guardian incompetent Craig

individuals in LTC who do not have a representative. The completed HHS 14-78 is to be sent to Craig Liaison at mail stop 0-95.

**B.
How to
Identify
Craig v
Bonta
Beneficiaries**

DHCS has created three new aid codes to identify Craig beneficiaries on **MEDS CRAIG AID CODES:**

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1E	Aged
2E	Blind
6E	Disabled

Additionally, MEDS contains the following information that can be used to identify Craig Beneficiaries.

MEDS	MEDS Screen
Eligibility status code ending with 6	INQM
Notice type	INQB
Government responsibility code of 3	INQM
Case number beginning with 9 followed by the beneficiary's SSN	INQM

**C.
How to
Identify SSI
Groups on
Meds**

Craig beneficiaries are in one of the following six groups. The Pickle Code on the MEDS INQM screen identifies these groups.

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No Longer Disabled	DHCS will continue to put the No Longer Disabled population in non- <u>Craig</u> aid code 6N for three months. If the beneficiary files an appeal, the person remains in aid code 6N throughout the appeal process. If the beneficiary loses his/her appeal or does not file the appeal within three months, MEDS will change the aid code to 6E. At that time, the beneficiary will appear on the monthly Exception Eligible report with an aid code of 6E, and workers must complete an SB 87 redetermination on the beneficiary. MEDS will use a Pickle Type "D" to identify this population.
Disabled Adult Child	DHCS will place the Disabled Adult Child (DAC) in aid code 2E or 6E. MEDS will use a Pickle Type "T" to identify this population. For this group, workers are to review for DAC Program eligibility before reviewing for any other Medi-Cal program.
Disabled Widow(er)	DHCS will place the Disabled Widow(er)

	and surviving divorced spouse in aid code 6E. MEDS will use a new Pickle Type “W” to identify this population. For this group, workers are to review for Disabled Widow(er) eligibility before reviewing for any other Medi-Cal program.
Pickle	DHCS will place the Pickle person in aid code 1E, 2E, or 6E. MEDS will continue to use Pickle Type “C” to identify this population. For this group, workers are to review for Pickle eligibility before reviewing for any other Medi-Cal program.
All Others Discontinued from SSI/SSP	DHCS will place a person discontinued from SSI for any other reason in aid code 1E, 2E or 6E. MEDS will use a Pickle Type “X” to identify this population. This group does not require a disability evaluation. As true for all groups, do an SB 87 <i>ex parte</i> review to determine if there is ongoing eligibility.
Long Term Care	MEDS will use a new Pickle Status “L” to identify this population.

**D.
SB 87
Process for
Craig
Beneficiaries**

The following are the steps the worker shall take, in the order listed, when they complete the SB 87 redetermination for Craig beneficiaries:

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Step	Action
1	Send the beneficiary the following required forms: MC-219, MC-007, DHS 7007, and DHS 7077A.
2	Do an <i>ex parte</i> review using all sources of information available, including the MEDS INQX – SSI/SSP Information screen (Appendix B), IEVS, or county case information currently active or active within the past 45 days.
3	If an eligibility determination cannot be made based on the <i>ex parte</i> review, attempt to contact the beneficiary by phone. The MEDS INQA – Address Information screen may show a telephone number for the beneficiary. If it is not available on the INQA screen, or the number is incorrect, then use other county resources. When an eligibility determination can be made based on the <i>ex parte</i> review and information received in the telephone call, the worker shall grant the case.
4	If the <i>ex parte</i> review and attempted phone contact do not provide enough information to make an eligibility determination, send a notice requesting the missing information. Attempt a second phone contact.

5	Give the beneficiary 20 days to provide the requested information.
6	If the beneficiary does not respond within 20 days, deny the case and send him/her a Medi-Cal discontinuance notice for the end of the month in which 10-day notice can be given and send HHSA 14-28 to the MEDS clerk to deny the SB 87 Medi-Cal determination which will discontinue the <u>Craig</u> case on MEDS (see Appendix D regarding completing HHSA 14-28).
7	If the beneficiary provides only partial verification, attempt to contact him/her by telephone and in writing to request the missing verification. If the beneficiary does not provide within 10 days from the date of the second notice, deny the case and send discontinuance NOA (allowing for 10-day notice). Send a HHSA 14-28 to the MEDS clerk to deny the SB 87 Medi-Cal determination which will discontinue the <u>Craig</u> case on MEDS (see Appendix D regarding completing HHSA14-28).
8	If the beneficiary returns all the information within 30 days after termination, determine eligibility as though he/she returned the information timely. If the beneficiary is eligible, grant the case. This will override MEDS with the appropriate approval code and end the <u>Craig</u> eligibility.
9	If the missing verification notice returns in the mail as loss of contact because the Post Office could not deliver it to the intended person, had no forwarding address, or marked it undeliverable, deny the case and send a 14-28 to the MEDS clerk to deny the SB 87 Medi-Cal determination which will discontinue the <u>Craig</u> case on MEDS (see Appendix D regarding completing HHSA 14-28). Send a discontinuance NOA to last known address.
10	If SSA discontinued the beneficiary due to loss of contact, the worker still needs to follow the <i>ex parte</i> process. If the Post Office returns the notice as undeliverable, deny the case and send a discontinuance notice, and submit a HHSA 14-28 to the MEDS clerk to deny the case on MEDS which will discontinue the case on MEDS (see Appendix D regarding completing HHSA 14-28).

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**E.
Case/MEDS
Actions**

Approvals - If the Craig beneficiary is eligible to ongoing Medi-Cal benefits, grant the case. A notice must be given to discontinue Craig benefits effective the first of the month following adequate 10-day notice. The granting action will override MEDS with the appropriate aid

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code. This ends Craig eligibility.

Denials - If the Craig beneficiary is not eligible to ongoing Medi-Cal benefits, workers shall deny the case.

**F.
Redetermi-
nation Dates**

Craig cases discontinued after June 30, 2003 will be given a redetermination date 12 months from the date SSI discontinued.

If the Craig beneficiary is added to an already active Medi-Cal case for other family members, a case comment must be made indicating the former Craig beneficiary's redetermination due date. If the case redetermination date for the family is prior to the former Craig family member, and the family does not submit a statement of facts, other family members are to be discontinued and the renewal date reset through the end of the former Craig beneficiary's certification period.

MPG Letter # 598

4.16.05 Breast and Cervical Cancer Treatment Program (BCCTP)

**A.
General**

DHCS has the authority to complete eligibility determinations for BCCTP applicants under BCCTP rules. When a BCCTP beneficiary no longer meets the federal BCCTP requirements and will be discontinued from her BCCTP eligibility, an SB 87 eligibility review must be completed before her BCCTP benefits can be discontinued. DHCS does not have the authority to make determinations of eligibility for any other Medi-Cal program. Therefore, when DHCS determines that a woman is no longer eligible for Medi-Cal under the federal BCCTP rules; DHCS will continue the BCCTP benefits until the worker completes the eligibility determination.

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MPG LTR 609 (04/07)

**B.
County
BCCTP
Coordination**

When the worker needs to obtain a determination of BCCTP eligibility, the worker shall:

- Call (916) 322-3410 and inform DHCS that the case information is being faxed for a BCCTP eligibility determination.
- Complete Form MC 0373 (09/09) [Appendix G](#) with at least the following information:
 - The full name of the person,
 - Address and telephone number of the person,

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- CIN, current aid code and the county case number,
- Name and contact information of the worker making the referral.
- Fax the referral form to (916) 440-5693.
- Notify the applicant/beneficiary that the case is being referred to DHCS for an eligibility determination.

MPG LTR 692 (10/09)

**C.
Application
for Medi-Cal**

When an individual applies for Medi-Cal, they must be evaluated for eligibility under all Medi-Cal programs, including BCCTP. If the individual does not have linkage or will be denied by the worker, and the worker is aware that the individual has or declares to have breast and/or cervical cancer, the worker shall:

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1	Simultaneously refer the case to the Disability Determination Services Division – State Programs (DDSD-SP) for a disability determination. See Article 5.04 for eligibility criteria.
2	Make a notation on Box 10 of the DDSD-SP referral from (MC221) that the case information has been referred to BCCTP, or
3	Refer the case to DHCS BCCTP unit without a disability packet if the criteria for a disability packet are not met.

Referring the case to DHCS allows federal BCCTP eligible women to receive Medi-Cal benefits, including Accelerated Eligibility if eligible, while their disability determination is being reviewed.

MPG LTR 692 (10/09)

**D.
Redetermin-
ation and SB
87**

If a beneficiary is no longer eligible for their existing Medi-Cal program at the annual redetermination or when the beneficiary reports a change in circumstances, and the beneficiary has or declares to have breast and/or cervical cancer, the worker shall follow the SB 87 process to determine whether the individual is eligible for any other Medi-Cal program, including federal BCCTP if the individual is a woman under 65 years of age, before the individual is discontinued from the existing Medi-Cal program. In order to follow the SB 87 process, the worker shall:

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1	Simultaneously refer the case to DDSD-SP and BCCTP for an eligibility determination. See Article 5.04 for eligibility criteria.
2	Make a notation on Box 10 of the DDSD-SP referral from (MC221) that the case information has been referred to BCCTP.

3	Place the beneficiary in one of the SB 87 Pending Disability aid codes (6J, 6R, 5J or 5R) while a disability determination is made.
4	Not terminate the beneficiary's Medi-Cal eligibility until a determination has been made by DDSD-SP and, if the beneficiary is a woman under 65 years of age, DHCS BCCTP unit. OR
5	Refer the case to DHCS BCCTP unit without a disability packet if the criteria for a disability packet are not met.
6	If the beneficiary is a woman under 65 years of age, do not terminate her Medi-Cal eligibility until a determination has been made by DHCS BCCTP unit.

A full scope beneficiary with a pending DDSD referral decision when determined not eligible for the federal component of BCCTP must remain active in one of the SB 87 pending disability aid codes (6J or 6R) while a disability determination is pending

A restricted-scope beneficiary with a pending DDSD referral decision when determined not eligible for the federal component of BCCTP must remain active in one of the SB 87 pending disability aid codes (5J or 5R) while a disability determination is pending

MPG LTR 692 (10/09)

**E.
Receipt of
Decision
From DDSD**

When a case referred to DHCS by the worker is approved for federal BCCTP and the worker subsequently receives a DDSD decision of disability linkage to Medi-Cal, the worker shall check MEDS to determine if the beneficiary is still active in BCCTP (aid code 0N, 0P, or 0W). When the beneficiary is still federal BCCTP active, but now also eligible for Medi-Cal based upon disability, the worker shall:

Step	Action
1	Change Medi-Cal aid code to the correct disability aid code effective the first of the following month
2	Send approval notice explaining new aid code
3	If retro benefits were requested on original application, the worker shall process retroactive eligibility
4	Forward a copy of approval notice to the DHCS BCCTP unit.

DHCS will evaluate if the individual must be terminated from BCCTP or if she may continue under BCCTP. Continued eligibility for federal BCCTP occurs when the beneficiary has a Medi-Cal SOC or restricted Medi-Cal.

**F.
Ineligible for
Federal
BCCTP**

A woman can become ineligible for federal BCCTP Medi-Cal benefits when any of the following occurs:

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1	She turns 65 years of age.
2	<p>She has obtained creditable insurance coverage, as determined by DHCS. A woman having the following types of coverage would be considered to have creditable coverage:</p> <ul style="list-style-type: none"> • A group health plan • Health insurance coverage – benefits consisting of medical care (provided through insurance, reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer • Medicare • Medi-Cal (full-scope, zero SOC) • Armed Forces insurance, or • A state health risk pool <p>The following coverage is not considered to be creditable coverage:</p> <ul style="list-style-type: none"> • Limited scope coverage, such as those that only cover dental, vision, or long-term care, or • Coverage is only for a specific disease or illness, not including breast or cervical cancer.
3	<p>She no longer needs treatment for breast and/or cervical cancer, as determined by her treating physician.</p> <p>Only those cases where the woman is determined by DHCS staff to no longer meet the federal BCCTP eligibility criteria will be referred to the county. There are certain reasons for discontinuance from BCCTP Medi-Cal that do not require a redetermination. These exceptions are:</p> <ul style="list-style-type: none"> • Death, • Moved out of state, • Voluntary withdrawal from the Medi-Cal program, • Failure to cooperate, or • Fraud.

**G.
Beneficiary
Notification**

When the BCCTP beneficiary is determined no longer eligible for federal BCCTP Medi-Cal, DHCS staff will send a notice to inform her of this, as well as the reason for the discontinuance. The notice will advise the BCCTP beneficiary that she will continue to receive full-scope, zero SOC Medi-Cal or restricted Medi-Cal on an interim basis until the county makes a determination of her eligibility for any other Medi-Cal program. The notice also includes language to advise her that, during the redetermination, she will be asked by the worker to provide additional information on income, resources and family composition (see [Appendix I](#) BCCTP Informational Notice).

When it is determined that a BCCTP beneficiary is no longer eligible for federal BCCTP Medi-Cal, the beneficiary will continue to receive the same level of Medi-Cal benefits (full-scope or restricted) as she was receiving under BCCTP until an eligibility determination is reported to MEDS.

DHCS staff will notify Strategic Planning and Operational Support (SPOS) via secured e-mail when a BCCTP case requires a county redetermination under other Medi-Cal programs.

If DHCS staff has information that the beneficiary has an open Medi-Cal case at the county, such as Medi-Cal with a SOC or emergency/pregnancy- related Medi-Cal, BCCTP staff will include the county case information on the County Notification form with the county case number and worker code showing on MEDS to facilitate the county redetermination process as the county case worker may not be aware of the change in the BCCTP beneficiary’s circumstances that generated the BCCTP discontinuance. DHCS staff will send a copy of the case record by regular mail. The BCCTP case file may contain some or all of the following documents:

1.	BCCTP application (the screening and diagnosis to be blacked out)
2.	BCCTP continuing Eligibility Redetermination form if an annual redetermination was completed
3.	BCCTP Rights and Responsibilities form
4.	Statement of Citizenship, Alienage, and Immigration Status form (MC 13), if applicant did not declare she was born in the U.S. or U.S. territory.
5.	MEDS screen showing “QE” screen if DRA has been met.
6.	Verification/documentation of immigration status
7.	Copy of Social Security card or other identification, if available
8.	Health Insurance Questionnaire (DHS 6155) and
9.	BCCTP Medi-Cal NOA advising her of her discontinuance

	from federal BCCTP Medi-Cal.
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MPG LTR 609 (04/07)

**H.
Referral to
County for
Redetermin-
ations**

During the redetermination period, if the woman being discontinued from federal BCCTP Medi-Cal appears to be eligible for State-funded BCCTP coverage, DHCS staff will concurrently determine her eligibility under the State-funded BCCTP pending the outcome of the worker's Medi-Cal eligibility review. This concurrent review will ensure that a determination will be made if she is eligible under the State-funded BCCTP so that she may continue to receive cancer treatment without any break in coverage, if she is not eligible under any other Medi-Cal program. The table below shows when State-funded BCCTP may be approved.

If the county worker determined that the woman is ...	Then...
eligible for full-scope, no Share of Cost (SOC) Medi-Cal under another program,	the county worker will transfer the woman from interim Medi-Cal coverage at the end of the month to the full-scope Medi-Cal program and will not place her into State-funded BCCTP.
eligible for another Medi-Cal program, but with a limited scope of coverage or a SOC,	DHCS staff will determine if the woman is eligible for the state-funded program.

BCCTP aid codes are the responsibility of DHCS. BCCTP eligibility information is available in the MEDS secondary screens (Q1, Q2 or Q3). The BCCTP beneficiaries who will be discontinued from BCCTP benefits for the reasons identified above and who require a county Medi-Cal redetermination are in the three BCCTP aid codes, below:

OP	Federal BCCTP eligibility determined, full-scope, no-SOC Medi-Cal.
OU	Federal/State-funded – Restricted Medi-Cal services and State-funded cancer treatment and related services for women without Satisfactory Immigration Status (SIS) – redetermination does not include the State-funded services.
OV	Continuing Federal Restricted Services for those who were OU eligible's, but have exhausted their period of State-funded cancer treatment services, but still need treatment and still meet all federal BCCTP requirements except for SIS.

**I.
Interim Aid
Codes**

There are four interim aid codes and women will remain in the appropriate interim aid code until the county makes an eligibility determination.

The four BCCTP interim aid codes, scope of coverage and descriptions are listed in the table below.

Aid Code	Definition
0W	Transitional full-scope Medi-Cal coverage with no SOC to BCCTP beneficiaries terminated from aid code 0P because they have obtained age 65, acquire creditable health coverage, or are no longer in need of treatment for breast and/or cervical cancer.
0X	Transitional restricted Medi-Cal <i>and</i> State-funded cancer treatment and related services to BCCTP beneficiaries terminated from aid code 0U because they have obtained creditable health coverage, but their out-of-pocket expenses for the health coverage will exceed \$750 in the next twelve-month period and have not exhausted the 18 or 24 months of State-funded eligibility.
0Y	Transitional restricted Medi-Cal <i>and</i> State-funded cancer treatment and related services to beneficiaries terminated from aid code 0U because they have turned 65 years of age, have no creditable health coverage, and have not exhausted the 18 or 24 months of state-funded eligibility.
0L	Transitional, restricted Medi-Cal to beneficiaries: <ul style="list-style-type: none"> • Terminated from aid code 0U because they are no longer in need of treatment for breast and/or cervical cancer; • Terminated from aid code 0U because they acquired creditable health coverage, but their out-of-pocket expenses will <i>not</i> exceed \$750 in the next 12 month period; • Terminated from aid code 0V because they have obtained age 65, acquire creditable health coverage, or are no longer in need of treatment for breast and/or cervical cancer;

Note: For aid codes 0X and 0Y only - If the county does not make a determination before the end of the beneficiary's 18 months (for breast cancer) or 24 months (for cervical cancer) of State-funded eligibility, when State-funded eligibility ends the beneficiary will be placed into

aid code 0L until the county makes a determination

The worker, upon receipt of a BCCTP case, must complete the eligibility review within 60 days. The 60-day period begins from the date BCCTP staff sends the BCCTP Notification via secured e-mail. Unlike other Medi-Cal applicants, BCCTP applicants do not complete a standard Medi-Cal Statement of Facts form when they apply for Medi-Cal under BCCTP. BCCTP applicants complete an abbreviated BCCTP internet-based application and a modified BCCTP Rights and Responsibilities form at an enrolling provider's office. Because BCCTP has no income or resource requirement, and the beneficiary's household composition information is not obtained with the application, the beneficiary's BCCTP case file contains limited information that the county can use to complete the eligibility review. Counties shall use the SB 87 process to obtain any additional information required to make an eligibility determination for other Medi-Cal programs. There will be no MC 210 in the case file.

MPG LTR 731 (10/11)

**J.
Exception
Eligible
Tracking
Report**

The state mandates that counties track those beneficiaries discontinued from federal Medi-Cal benefits under the BCCTP program. The counties will receive an "Exception Eligibles" (EE) tracking report on a monthly basis. The EE report is a tool for ensuring the interim BCCTP cases have a completed county eligibility determination. The EE report will show the number of months the beneficiaries have been in a BCCTP interim Medi-Cal aid code pending county redetermination.

ACWDL
11-29

In order to assist FRCs in tracking and monitoring BCCTP referrals, automation staff has generated the [Exception Eligible Tracking Report](#). The report will be uploaded to SharePoint monthly.

EXCEPTION ELIGIBLES TRACKING REPORT DEFINITIONS

TITLE	DEFINITION	AID CODE	MEDS ALERT(S)
SB87-BCCTP	Breast and Cervical Cancer Treatment Program	0W, 0X, 0Y, 0L	9548

MPG LTR 731 (10/11)

**K.
Informing
Notices**

When the worker receives a case for redetermination and the worker pends the case in CalWIN, CalWIN will send a transaction to report the date the county received the case and started the redetermination process.

ACWDL
06-25

The worker must ensure that these beneficiaries receive copies of the forms in the standard Medi-Cal information notices, including those in the table below, so that they have necessary information about property and spend down.

Form #	Title
MC 007	Medi-Cal General Property Limitations
MC 219	Important Information for Persons Requesting Medi-Cal
DHS 7077	Notice Regarding Standards for Medi-Cal Eligibility
DHS 7077A	Notice Regarding Transfer of Home for both a Married and an Unmarried Applicant/Beneficiary

MPG LTR 609 (04/07)

**L.
SB 87
Process**

The worker must make additional contacts with the beneficiary to obtain information to complete the eligibility review. If workers have specific case questions or need additional information from BCCTP, they should contact the BCCTP Eligibility Specialist assigned to the case. The BCCTP Eligibility Specialist e-mail address and telephone number can be located on the BCCTP County Notification form. All BCCTP Medi-Cal cases referred to the worker for a Medi-Cal determination must be redetermined under the SB 87 three-step process summarized in the table below. Workers must follow each step sequentially until the beneficiary's continued Medi-Cal eligibility or ineligibility is accurately determined

ACWDL
06-25

Step	Action
1.	<i>Ex parte</i> review.
2.	Direct Contact
3.	Request for Information Form (MC 355).

NOTE: There will not be any special transaction entries required to change a BCCTP interim aid code to another Medi-Cal program aid code because the county's transaction on the outcome of the eligibility determination will automatically terminate the beneficiary's interim aid code benefits. Therefore, it is important the county's determination be reported to MEDS timely and correctly.

MPG LTR 609 (04/07)

**M.
Example of
Process**

The following example illustrates a seamless eligibility determination process for county and State-funded BCCTP staff. During the annual redetermination, a BCCTP beneficiary has been determined to have creditable health coverage and not eligible for full-scope Medi-Cal benefits under aid code 0P. However, the beneficiary’s estimated out-of-pocket expenses for the next 12 months will exceed \$750; she would be eligible for State-funded BCCTP coverage if she is not eligible for other full-scope, no SOC Medi-Cal benefits.

Step	Action
1.	State BCCTP Eligibility Specialist (ES) completes MEDS online transaction on June 18, 2011, and places the beneficiary into interim aid code 0W effective July 1, 2011, pending the county’s determination under all other Medi-Cal programs.
2.	State BCCTP ES sends referral to the County on June 20, 2011.
3.	County receives the referral packet on July 1, 2011, and completes MEDS transaction to show application pending status.
4.	County receives the EE-BCCTP Report showing the beneficiary interim aid code status.
5.	County completes the SB 87 process on August 20 2011, and finds beneficiary not eligible for other full-scope, no SOC Medi-Cal.
6.	County performs a MEDS transaction on August 20, 2011, to deny on MEDS. This transaction automatically terminates BCCTP interim aid code and sends a ten-day NOA, effective August 31, 2011, (denial action will generate a worker alert to BCCTP ES).
7.	BCCTP ES receives MEDS worker alert on August 21, 2011, and verifies the county’s action on MEDS on August 22, 2011.
8.	State BCCTP ES places the beneficiary into the State-funded program (aid code 0R) on September 1, 2011 to ensure the beneficiary continues to have access to cancer-related treatment and services.
9.	State BCCTP ES will send the beneficiary an Eligibility Letter to inform them of their eligibility to State-funded BCCTP (see Appendix J BCCTP Discontinuance Notice).

**N.
Redetermination Dates**

If a former BCCTP beneficiary is being added to an existing Medi-Cal Family Budget Unit (MFBU), the Annual Redetermination date for this individual is the same redetermination date as the other members in the MFBU. For all other BCCTP women, who are determined eligible for Medi-Cal, the Annual Redetermination date will be 12 months from the month the county completes the redetermination under another Medi-Cal program. For example:

ACWDL
06-25

Action	Date
BCCTP beneficiary placed in interim Medi-Cal aid code:	June 2011
Worker receives BCCTP case file and pends the case:	June 2011
Worker approves full scope, no-cost Medi-Cal:	August 2011
Next Annual Redetermination is due.	July 2012

The full-scope BCCTP Medi-Cal eligibles have voluntary enrollment in Managed Care.

MPG LTR 609 (04/07)

**O.
State Hearings and Appeals**

All beneficiaries in these three federal BCCTP Medi-Cal aid codes have the same hearing and appeal rights as any other Medi-Cal beneficiary, including the right to aid paid pending an appeal, if the hearing is requested within ten days of the notice or before the termination takes effect.

ACWDL
06-25

If the woman...	Then the...
Files an appeal on the BCCTP Medi-Cal discontinuance,	BCCTP ES will prepare the position statement.
Is denied Medi-Cal based on the worker's determination and she files an appeal,	County appeals representative will need to prepare the position statement.

MPG LTR 609 (04/07)

Appendix A Codes and NOA's / MEDS INQP Screen

A. Appeals

APPEAL-DATE - This field will give the date an appeal was filed.

APPEAL-LEVEL - There are many codes that may appear in this field. The key codes that workers need to be aware of are:

- R Reconsideration
- H Hearing
- A Appeals Council Review

NOTE: SSA updates appeals information on a recipient's SSI/SSP Medi-Cal record **only** if a change occurs. Because of this, some records on MEDS will reflect previously used Appeals Level Codes. This can be problematic since an "A" previously indicated a "First Level Appeal" and an "R" indicated the "Hearing Was Denied." The current codes were implemented October 23, 2000. If the Appeals-Date on the MEDS INQP screen is prior to that, the code used was a previous code.

DECISION CODES - The following codes indicate the decision rendered on the appeal:

AD	Dismissed/Abandoned
FA	Favorable/SSA Appeal
FC	Fully/Partially Favorable
FF	Fully Favorable
FN	Favorable/SSA Not Appealed (court case only)
OT	Closed: Other
PF	Partially Favorable
T1	Dismissed Claimant Decreased
UA	Unfavorable/Appealed By Recipient (court case only)
UF	Unfavorable
UN	Unfavorable/Not Appealed by Recipient (court case only)
WC	Dismissed/Withdrawn (converted with record only)
WD	Dismissed: Withdrawn
1D	Dismissed: Cannot Be Appealed
2D	Dismissed: Filed By Improper Requestor
3D	Dismissed: Filed Late Without Good Cause
4D	Dismissed: Withdrawn

**B.
Notice of
Actions**

NOA-DATE - This field gives the date of the most recent NOA that was mailed to the former SSI recipient.

NOA-TYPE - This field gives the type of NOA that was sent to the former SSI recipient. The following codes will appear in this field:

22	DHS Notice Type 22. This notice informs the beneficiary that cash benefits were terminated, but Medi-Cal will continue while a "redetermination" is made. In order to be redetermined, the beneficiary must complete the enclosed forms.
23	DHS Notice Type 23. This notice informs the beneficiary that the SSI-based Medi-Cal will be discontinued because no forms were submitted to the county.
26	DHS Notice Type 26. This notice informs the beneficiary that if a timely SSI appeal is filed because they do not agree with SSA's decision that they are no longer disabled, Medi-Cal will continue through the SSA appeals process.
28	DHS Notice Type 28. This notice informs the beneficiary that the notice of the discontinuance of Medi-Cal benefits they received from the county should not have been sent and their Medi-Cal benefits will continue.
CO	The beneficiary was sent a county generated NOA informing him or her that their SSI-based Medi-Cal will be discontinued as a result of the "redetermination." No linkage could be established to continue Medi-Cal eligibility.
ND	Loss of SSI disability status (no NOA issued). This code is posted at <u>Ramos</u> processing when DHS receives SDX information that a case is in no longer disabled status. This code will stay in the system until it is overwritten by another code such as 22 or 23.

Appendix B Discontinued CalWORKs Reasons *Ex Parte*/1931(b)/Aid Code 38 Table

REASON FOR CALWORKS DISCONTINUANCE	ELIGIBLE TO AUTOMATIC 1931(b) CONVERSION AFTER 38 PLACEMENT	EVALUATION FOR ALL MEDI-CAL PROGRAMS REQUIRED AFTER 38 PLACEMENT
Loss of California residency	No	No
Written request to discontinue CalWORKs and Medi-Cal	No	No
Incarceration	No	No
Death of beneficiary	No	No
Transition into another Public Assistance (PA) program that provides Medi-Cal benefits	No	No
Failure to cooperate with child/medical support requirements (applies to custodial parent or caretaker relative only and not children or pregnant women up to 60 days post partum)	No	No
Failure to provide monthly income report	Yes	No Unless worker later becomes aware of a change that affects 1931(b) eligibility.
Non-cooperation with Welfare-to-Work requirements	Yes	No
Expiration of CalWORKs time limits	Yes	No
Failure to complete the CalWORKs annual redetermination	No	Yes
Loss of contact/whereabouts unknown	No	Yes
Only eligible child leaves home	No	Yes Evaluate for pending disability, if alleged.
Change in household composition that has resulted in non-cooperation with the evidence gathering requirements for the AU	No	Yes
Change in household circumstances that affect Medi-Cal eligibility	No	Yes
Resources exceeds limits	No	Yes Potential FPL
Income exceeds standards	No	Yes
18 year old turns 19	No	Yes Potential CEC
CalWORKs parent(s) is transferred to the Family Reunification Program after children are removed from the home	No	Yes

Appendix C Craig v Bonta Automation

A. Worker Action

Review file clearance information on MEDS/SCI

- Craig aid codes are 1E, 2E, or 6E
- Craig county ID will be 37-1E-9 (10 digit CIN#) etc.
- Verify correct CIN#

Follow normal Medi-Cal application processing procedures as if processing a new application.

The client will not have dual eligibility under both the Craig v Bonta aid code and another Medi-Cal program aid code so granting actions must be taken effective the first of the future month. (Granting actions taken by the county before or after MEDS renewal will cause MEDS to automatically terminate the Craig record at the end of current month and record ongoing eligibility effective the first of the future month.)

If denying the application, the worker must submit a 14-28 HHSN MEDS Network On-Line Request form to MEDS Operator with the following information:

- 14 digit county ID (county code of 37-aid code of 1E- 7 digit county case serial number-last digit of FBU-person number)
- birth date (same as Craig record on MEDS)
- MEDS ID (SSN or pseudo – same as Craig record on MEDS)
- CIN#
- Application date (date county began SB87 determination/county application date)
- Application flag (valid county value is P)
- Denial date
- Denial reason (see MEDS Quick Reference Guide)

Although we are denying a Medi-Cal application, the worker will send a NOA to notify the client that temporary Craig v Bonta benefits have discontinued, or that temporary Craig v Bonta benefits have discontinued and ongoing eligibility has been established under another Medi-Cal program.

MEDS will produce monthly (Renewal) Exception Eligible Reports to reflect the number of months a “Craig v Bonta” beneficiary has remained in aid code 1E, 2E, or 6E.

B. Meds Operator Action

MEDS Operator will process the 14-28 and submit the AP18 on-line transaction to report the denial with the information listed above from the worker.

MPG Letter #529

Appendix D Public Administrator/Craig v Bonta Referral

PUBLIC ADMINISTRATOR/ CRAIG VS BONTA REFERRAL

CLIENT/PROPOSED CONSERVATEE NAME _____

ADDRESS _____

TELEPHONE NUMBER _____ DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____

NAMES, ADDRESSES, TELEPHONE NUMBERS AND RELATIONSHIP OF ANY KNOWN RELATIVES OR KEY CONTACT PERSONS:

STATE EXAMPLE(S) OF PROBABLE CAUSE TO BELIEVE THAT THE CLIENT IS SUBSTANTIALLY UNABLE TO MANAGE HIS/HER FINANCIAL RESOURCES AND THAT THERE EXISTS A SIGNIFICANT DANGER THAT THE CLIENT WILL LOSE ALL OR A PORTION OF THEIR PROPERTY WITHOUT IMMEDIATE INTERVENTION:

CURRENT BALANCE OF TRUST ACCOUNT AND ANY OTHER KNOWN ASSETS:

PLEASE PROVIDE ANY ADDITIONAL INFORMATION THAT MIGHT ASSIST US IN OUR INVESTIGATION ON THE REVERSE OF THIS FORM

REFERRED BY _____
Telephone Number _____

Appendix E Discontinued IHSS Residual Case Automation

A. Worker Action

Review the file clearance information on MEDS/SCI.

Step	Action
1	Discontinued IHSS Residual Cases convert from 18, 28, and 68 to 14, 24, or 64 aid codes on MEDS.
2	Workers must match MEDS when Performing "Application Registration" process.
3	Follow SB 87 Medi-Cal determination processing guidelines.
4	Granting actions must be taken effective the first of the future month. (Granting actions taken by the county before MEDS renewal will post ongoing eligibility effective the first of the future month forward. Granting actions taken by the county after MEDS renewal should have an effective date of the first of the future month.)
5	<p>If the application is denied, the worker must submit a 14-28 HHSa MEDS Network On-Line Request form to the MEDS Operator with the following information:</p> <ul style="list-style-type: none"> • 14 digit county ID (county code of 37-aid code - 7 digit county case serial number-last digit of FBU-person number) • Birth date (same as existing record on MEDS) • MEDS ID (SSN or pseudo – same as existing record on MEDS) • CIN # • Application date (date county began SB 87 determination/county application date) • Application flag (valid county value is P) • Denial date <p>Denial reason (see attachment to MPG Letter # 529 or MEDS Quick Reference Guide).</p>
6	If the application is denied, the worker shall send a notice informing the beneficiary that the temporary benefits from the discontinued IHSS Residual case will be discontinued, with the date of discontinuance written on the notice. A separate denial notice must also be sent out for denials other than failure to provide necessary information.
7	If the application is approved, a granting notice must be sent out informing the beneficiary that eligibility has been established under another Medi-Cal Program.
8	If the discontinued IHSS Residual recipient has moved to another county, an ICT must be processed and online

	transaction needs to be submitted to update MEDS with the current residence address and residence county.
--	---

**B.
MEDS
Operator
Action**

MEDS Operator will process the 14-28 and submit the AP18 on-line transaction to report the denial with the information listed above from the worker.

MPG Letter #529

Appendix F Craig v Bonta Questions and Answers

ACWDL
04-31

QUESTION 1:

Workers were instructed (in MPG Special Notice 01-12, issued July 26, 2001) to evaluate the beneficiary for his/her continued eligibility under various avenues of eligibility, including the allegation of disability. If the Social Security Administration (SSA) discontinuance reason is “no longer disabled,” can the beneficiary still use a disability allegation to obtain Medi-Cal eligibility?

ANSWER 1:

Yes, but only if the person alleges to have a disability different from the disability under which the SSI/SSP was granted. A recipient may be referred to DDS if they had a previous disability, are discontinued from Medi-Cal for a reason other than their alleged disability (such as income) and are reapplying for Medi-Cal based on the allegation the disability continues to exist.

QUESTION 2:

Upon completing the SB 87 Redetermination, the worker finds that the beneficiary continues to remain eligible for full-scope coverage, but under another Medi-Cal program. Is the worker required to send a notice of action?

ANSWER 2:

Yes. Workers are required to notify beneficiaries in writing of their Medi-Cal eligibility or ineligibility, and of any changes made in their eligibility status or SOC.

QUESTION 3:

Are Craig beneficiaries dual-aid types eligible? For example, if the worker receives an application April 15, 2006, and determines eligibility on May 28, 2006, does the worker grant eligibility back to the date the application was received or does the worker grant eligibility on July 1, 2006, after the June 2006 MEDS renewal process?

ANSWER 3:

Craig beneficiaries are not dual-aid type eligible nor can the worker require a Craig eligible person to complete an application for Medi-Cal benefits. If, however, the application is voluntarily mailed or given to the worker before an SB 87 Redetermination is processed, it can be used to complete the SB 87 Redetermination. However, continuous eligibility in the State assigned Craig aid codes on MEDS remains until the worker redetermines the eligibility and submits a transaction to MEDS. The ongoing eligibility information is only applied to the MEDS pending month of eligibility.

QUESTION 4:

When the worker sends a MEDS transaction to discontinue Craig eligibility due to Medi-Cal eligibility or ineligibility well in advance of the MEDS renewal date, we are finding that some of these cases are not being discontinued on the date we expect them to be discontinued.

ANSWER 4:

The MEDS logic was designed to use the denial date in the transaction to determine the discontinuance date. The worker must enter the denial date, not the date that they want the Craig eligibility to discontinue.

QUESTION 5:

After conducting an SB 87 Redetermination, it is determined that the beneficiary is eligible to Medi-Cal and that they are part of an existing MFBU. Do we align the Craig individual's SB 87 redetermination date to the family's annual redetermination date or do we realign the MFBU to the SB 87 Redetermination date?

ANSWER 5:

If a Craig individual is being added to an existing MFBU, realign his/her annual redetermination date so that it is the same annual redetermination date as the other family members in the MFBU. If, however, under the CEC provisions, the Craig individual happens to be a child under the age of 19, the worker must determine if the child's eligibility goes beyond the family's annual redetermination date.

QUESTION 6:

When the worker contacts the client and provides the correct forms for the Medi-Cal determination, do we apply a SOC to the current month or the following month?

ANSWER 6:

Regulations require any negative action (including increasing the SOC) to be applied after a ten-day notice of adverse action has been mailed.

Appendix G County Referral to the Breast and Cervical Cancer Treatment Program

State of California – Health and Human Services Agency

Department of Health Care Services

COUNTY REFERRAL TO THE BREAST AND CERVICAL CANCER TREATMENT PROGRAM

To: Department of Health Care Services Breast and Cervical Cancer Treatment Program MS 4611 P.O. Box 997417 Sacramento CA 95899-7417 Phone number: 916-322-3410 Fax number: 916-440-5693		From: Name of County: Name of Eligibility Worker (EW): Phone number of EW: Fax number of EW:	
Applicant/Beneficiary Information:			
Name:		Phone number:	Alternate/message phone number:
Address:(number, street)		City:	Zip Code:
Authorized Representative: <input type="checkbox"/> Yes <input type="checkbox"/> No	AR Name:	AR Phone number:	Applicant's/beneficiary's primary Language:
Case number:		CIN:	
Case Information (check all that apply):			
<input type="checkbox"/> Referral is for an applicant. <input type="checkbox"/> Referral is for a beneficiary. <input type="checkbox"/> Case referred to the Disability Determination Service Division – State Programs for a disability evaluation <input type="checkbox"/> Beneficiary put into an SB-87 Pending Disability aid code (6J, 6R, 5J or 5R).			
Comments:			

Appendix H Breast and Cervical Cancer Treatment Program (BCCTP) Flyer

BREAST AND CERVICAL CANCER TREATMENT PROGRAM (BCCTP)

The BCCTP may provide Medi-Cal to low-income people that live in California and have breast and/or cervical cancer.

If you have been denied Medi-Cal or you are no longer eligible for Medi-Cal through your county and you have breast and/or cervical cancer, tell your county Eligibility Worker (EW). Your EW can make a referral for you to the BCCTP.

An Eligibility Specialist (ES) from the BCCTP will call or write to you for more information. The requested information will help us to see if you are eligible for the program. You may be Medi-Cal eligible through the BCCTP if you are a woman and you meet the following requirements:

- Have been screened and found in need of treatment for breast and/or cervical cancer, follow-up care for cancer, or precancerous cervical lesions/conditions by an Every Woman Counts (EWC) or Family Planning, Access, Care and Treatment (FamPACT) provider; and
- Are a California resident; and
- Are under age 65; and
- Are a United States citizen or have satisfactory immigration status; and
- Have no other health insurance including full-scope no share-of-cost Medi-Cal, or Medicare; and
- Have a monthly gross family income, at the time of screening and diagnosis, that is at or below 200 percent of the federal poverty level.

If you have been screened for breast and/or cervical cancer by a provider that is not with EWC or FamPACT, you can still be referred to the BCCTP. Your BCCTP worker will help you find an EWC or FamPACT provider that can confirm your diagnosis.

Even if you do not meet all the above requirements, you may still receive BCCTP through the State-funded BCCTP. The State-funded BCCTP can help you for up to 18 months for breast cancer or up to 24 months for cervical cancer. The State-funded BCCTP is available to men and women, regardless of immigration status.

For additional information or questions on the BCCTP, call 1-800-824-0088

Appendix I Breast and Cervical Cancer Treatment Program (BCCTP) Informational Notice – Enclosure 1



State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
Governor

BREAST AND CERVICAL CANCER TREATMENT PROGRAM Informational Notice

Notice Date:
Case Tracking No.:
Elig. Specialist (ES):
ES Telephone:
ES Fax Telephone:
ES Work Hours:
Notice for:

The Breast and Cervical Cancer Treatment Program (BCCTP) provides no-cost Medi-Cal benefits for women who are California residents, under age 65, citizens/nationals of the United States or have satisfactory immigration status, and have been diagnosed with, and are in need of treatment for, breast and/or cervical cancer, but do not have adequate health care coverage. You have been getting Medi-Cal benefits under BCCTP at no cost to you.

BCCTP has determined that

_____ You have adequate health coverage (can include Medicare).

_____ You are 65 years of age as of ____.

_____ You no longer need treatment for breast and/or cervical cancer.

Due to the above reason you are no longer eligible for Medi-Cal through BCCTP; however, Medi-Cal rules require that a redetermination of your eligibility under other Medi-Cal programs be made before we can change or stop your Medi-Cal benefits. While your eligibility for another Medi-Cal program is being determined by the county, **you will continue to get the same Medi-Cal benefits through the BCCTP.**

The county social services office in your county of residence, _____, will see if you are eligible for another Medi-Cal program. Because other Medi-Cal programs have different eligibility rules from BCCTP, the county will ask you for information on your income, family size and any resource or property that you may have. BCCTP is also sending a copy of your file to the county to help with the review process. The county will make a separate determination based on the information you provide to them and notify you in writing of your eligibility or ineligibility for another Medi-Cal Program.

If you have any questions regarding your eligibility for Medi-Cal, please contact your county social services agency at _____ for more information.

You will also receive an official discontinuance Notice of Action (NOA) from BCCTP when the county completes their determination. If the county finds you are not eligible for another Medi-Cal program, or if you are eligible for another Medi-Cal program with a share of cost and you have not previously been in the state-funded BCCTP, BCCTP will review your case to see if you are eligible for the state-funded BCCTP. The state-funded BCCTP provides breast and cervical cancer treatment and related services only for 18 months for breast cancer and/or 24 months for cervical cancer.

If you have questions about this notice, please contact your BCCTP worker within 15 working days.

Do not throw your plastic Benefits Identification Card (BIC) away. You still need your BIC to get health care services for as long as you are eligible for Medi-Cal. Always show your BIC to your medical provider whenever you need care.

The statutes that require this action are Sections 14007.71 and 14019 of the Welfare and Institutions Code.

Appendix J Breast and Cervical Cancer Treatment Program (BCCTP) RV Discontinuance Notice – Enclosure 2



State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
Governor

BREAST AND CERVICAL CANCER TREATMENT PROGRAM
Discontinuance of Medi-Cal benefits

Notice Date:
Case Tracking No.:
Elig. Specialist (ES):
ES Telephone:
ES Fax Telephone:
ES Work Hours:
Notice for:

Effective _____, your Medi-Cal coverage under the Breast and Cervical Cancer Treatment Program (BCCTP) will be discontinued.

The reason for the discontinuance is:

- You have adequate health coverage (can include Medicare).
- You are 65 years of age as of ____.
- You no longer need treatment for breast and/or cervical cancer.

Medi-Cal rules require that, before your coverage is stopped, a determination must be made under all other Medi-Cal programs. We forwarded a copy of your BCCTP case record to your local county Medi-Cal office for a Medi-Cal eligibility determination. BCCTP continued to give you Medi-Cal coverage while the county made an eligibility determination. The county has completed the eligibility review and informed you of the outcome of their Medi-Cal review. If you have any questions regarding the county's Medi-Cal eligibility determination, please contact your county social services agency for more information.

If you are determined ineligible for another Medi-Cal program, or if you are eligible for another Medi-Cal program with a share of cost and you have not previously been in the state-funded BCCTP, your case will be reviewed by BCCTP to see if you are eligible for the state-funded BCCTP. The state-funded BCCTP provides breast and cervical cancer treatment and related services only for 18 months for breast cancer and/or 24 months for cervical cancer. You will receive a separate notice regarding your state-funded BCCTP eligibility.

If you have questions about this notice, please contact your BCCTP worker within 15 working days.

Do not throw your plastic Benefits Identification Card (BIC) away. You still need your BIC to get health care services for as long as you are eligible for Medi-Cal. Always show your BIC to your medical provider whenever you need care.

Please see the enclosed important information about your hearing rights.

The statutes that require this action are Sections 14005.37 and 14007.71 of the Welfare and Institutions Code.