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.

MEM 50183

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.

MPG Letter #452

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.

MPG Letter #598

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.

D. Eligibility Requirements - RCA/CHEP Referrals

ACWDL 03-29

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.

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 Discontinuance

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.

ACWDL 01-36

B. CalWORKs Discontinuance 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 Discontinuances

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.

MPG Letter #242

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: ACWDL 01-36

- 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.).

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.

MPG Letter # 520

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.

MPG SNs 01-01 and 01-01 Add. A

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.

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

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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 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:

MPG SN 00-01

- 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.

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. ACWDL 03-24

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. ACWDL 03.25

A new abbreviated referral form HHSA 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 HHSA 14-78 is to be sent to Craig Liaison at mail stop 0-95.

B. How to

DHCS has created three new aid codes to identify Craig beneficiaries on **MEDS CRAIG AID CODES:** ACWDL 03-24

Identify Craig v Bonta Beneficiaries

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

ACWDL 03-24

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

No Longer Disabled	DHCS will continue to put the No Longer Disabled population in non-Craig 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 *ex parte* 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

ACWDL 03-24

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

Step	Action
1	Send the beneficiary the following required forms: MC-219, MC-007, DHS 7007, and DHS 7077A.
2	Do an *ex parte* 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 *ex parte* 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 *ex parte* review and information received in the telephone call, the worker shall grant the case.
4	If the *ex parte* 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 Craig 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 Craig 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 Craig 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 Craig 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 *ex parte* 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).

MPG Letter #529

E. Case/MEDS Actions

ACWDL 03-24

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 code. This ends Craig eligibility.

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

F. Redetermination 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

Revision Date:
July 17, 2017

Background:
DHCS has the authority to complete eligibility determinations for BCCTP applicants under BCCTP rules. When a BCCTP beneficiary no longer meets BCCTP requirements and will be discontinued from BCCTP eligibility, an SB 87 eligibility review must be completed before 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 an individual is no longer eligible for Medi-Cal under the BCCTP rules; DHCS will continue the BCCTP benefits until the county completes the eligibility determination. This section is being revised to add ACWDL 17-11 additional timeframes for persons diagnosed with recurring cancer. Processing Guide #24 contains the BCCTP evaluation procedures.

Policy:
A. Eligibility Determination
The county completes the eligibility determination when:

- DHCS determines that an individual is no longer eligible for Medi-Cal under the BCCTP rules
- Aware that the applicant has or declares to have breast and/or cervical cancer and does not have linkage or will be denied Medi-Cal
- 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

B. County BCCTP Coordination
To obtain a determination of BCCTP eligibility, complete referral form MC 373 (09/09), located in forms repository, following all instructions. For expedited instructions see Processing Guide 24.

C. Application for Medi-Cal
A Medi-Cal applicant must be evaluated for eligibility under all Medi-Cal programs, including BCCTP. See Processing Guide 24 for steps to take when the individual does not have linkage or will be denied, and the worker is aware that the individual has or declares to have breast and/or cervical cancer.

D. Redetermination and SB87
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, follow the SB 87 process in Processing Guide 24 to determine if the individual is eligible for any other Medi-Cal program, including federal BCCTP.

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.

E. Receipt of Decision from DDSD

See Processing Guide 24 for the steps when a case referred to DHCS is approved for federal BCCTP and a DDSD decision of disability linkage to Medi-Cal is received.

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

F. Ineligible for Federal BCCTP

Only the cases where the individual is determined by DHCS to no longer meet the federal BCCTP eligibility criteria will be referred to the county for a redetermination. An individual can become ineligible for federal BCCTP Medi-Cal benefits when any of the following occurs:

1. Turns 65 years of age
2. Has obtained creditable insurance coverage, as determined by DHCS. The following types of coverage would be considered creditable coverage:
    - o A group health plan
    - o 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 contract or health maintenance organization contract offered by a health insurance issuer.
    - o Medicare
    - o Medi-Cal (full-scope, zero SOC)
    - o Armed Forces insurance, or
    - o A state health risk pool
3. No longer needs treatment for breast and/or cervical cancer, as determined by the treating physician

The following coverage is not considered to be creditable coverage:

- Limited scope coverage, such as those that only cover dental, vision, long-term care, or
- Coverage is only for a specific disease or illness, not including breast or cervical cancer

There are certain reasons for discontinuance from BCCTP Medi-Cal that do not require a redetermination. These exceptions are:

- 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 will send the BCCTP Informational Notice to inform the beneficiary of this, as well as the reason for the discontinuance. The notice will advise the BCCTP beneficiary that he/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 eligibility for any other Medi-Cal program. The BCCTP informational Notice also

includes language to advise the individual that during the redetermination he/she will be asked by the county worker to provide additional information on income, resources and family composition.

DHCS will notify the county via secured email when a BCCTP case requires a county redetermination under other Medi-Cal programs. If DHCS has information that the beneficiary has an active Medi-Cal case at the county, the email will include the county case information. DHCS will also mail a copy of the BCCTP file.

H. Referral to County for Redeterminations

During the redetermination period, if the individual being discontinued from federal BCCTP Medi-Cal appears to be eligible for State-funded BCCTP coverage, DHCS staff will concurrently determine eligibility under the State-funded BCCTP pending the outcome of the county worker's Medi-Cal eligibility review. This concurrent review will ensure that a determination will be made if eligible under the State-funded BCCTP so the individual may continue to receive cancer treatment without any break in coverage, if not eligible under any other Medi-Cal program. See Processing Guide 24 for actions to take when State-funded BCCTP may be approved.

County's Review

Upon receipt of a BCCTP case, the county 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 will use the SB 87 process (see 04.16.05L below) to obtain any additional information required to make an eligibility determination for other Medi-Cal programs.

I. BCCTP Aid Codes

1. 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: 0P, 0U, and 0V.

Interim Aid Codes

2. There are four interim aid codes; 0W, 0X, 0Y, and 0L. Persons will remain in the appropriate interim aid code until the county makes an eligibility determination.

Notes: 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.

Effective January 1, 2017 persons in aid codes 0R, 0T, and 0U, may be eligible for an additional 18 or 24 months of State-funded BCCTP eligibility once the current eligibility period expires, when diagnosed with recurring cancer and the individual continues to meet Medi-Cal eligibility.

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.

In order to assist FRCs in tracking and monitoring BCCTP referrals, automation staff has generated the Exception Eligible Tracking Report, Titled SB 87 – BCCTP. The report is uploaded to SharePoint Management Reports under Other Reports/Medi-Cal Reports/MEDS.

K. Informing Notices

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

Ensure these beneficiaries receive copies of the forms in the standard Medi-Cal information notices, including those listed below, so 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

L. SB 87 Process

Make additional contacts with the beneficiary to obtain information to complete the eligibility review. If there are specific case questions or additional information needed from BCCTP, they should contact the BCCTP Eligibility Specialist (ES) assigned to the case. The BCCTP ES e-mail address and telephone number can be located on the BCCTP County Notification form. All BCCTP Medi-Cal cases referred to the county for a Medi-Cal determination must be redetermined under the SB 87 three-step process below. Follow each step sequentially until the beneficiary's continued Medi-Cal eligibility or ineligibility is accurately determined.

1. *Ex parte* 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.

M. 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 individuals, 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.

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

N. State Hearing and Appeals

All beneficiaries in the 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.

If the beneficiary…	**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 he/she files an appeal,	County appeals representative will need to prepare the position statement.

Program Impact/s:

No Impact to other programs

References:

ACWDL 06-25
ACWDL 09-42
ACWDL 11-29
ACWDL 17-11

Sunset Date:

This policy will be reviewed for continuance on or by July 31, 2020

Approval for Release:

7-17-17

Rick Wanne, Director
Eligibility Operations

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. Notices of Action

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 Ramos 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

MPG Letter #571

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 HHSA MEDS Network On-Line Request form to MEDS Operator with the following information:
- 14 digit county ID (county code of 37-aid code of IE- 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.

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

14-78 (06/03)

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	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: • 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 Denial reason (see attachment to MPG Letter # 529 or MEDS Quick Reference Guide).
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 will process the 14-28 and submit the AP18 on-line

MEDS Operator Action	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 DDSD 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.