§ 50000. Meaning of Words.

Words shall have their usual meaning unless the context or a definition clearly indicates a different meaning. Shall means mandatory. May means permissive. Should means suggested or recommended.

§ 50001. Department. [Repealed]

§ 50002. Director. [Repealed]

§ 50003. Medi-Cal Program. [Repealed]

§ 50004. Medi-Cal Program Administration.

(a) The Department is the single state agency approved by the Secretary of the Department of Health and Human Services to administer the Medi-Cal program.

(b) The Department shall administer the Medi-Cal program in accordance with the following:

(1) The State Plan under Title XIX of the Social Security Act.

(2) Applicable State law, as specified in the Welfare and Institutions Code.

(3) Medi-Cal regulations.

(c) The county welfare department in each county shall be the agency responsible for local administration of the Medi-Cal program under the direction of the Department.

§ 50005. Medi-Cal Regulations.

Regulations promulgated by the Department for purposes of administering the Medi-Cal program shall be known as Medi-Cal regulations. These regulations comprise Division 3, Title 22, California Administrative Code.

§ 50006. Conformity with Federal Requirements. [Repealed]

§ 50007. Fiscal Intermediary.

Fiscal intermediary, as used in these regulations or in any other document pertaining to the Medi-Cal program and its administration, means any individual, partnership or association, corporation or institution contracting with the Department for the performance of fiscal services related to the program.

§ 50008. Liens. [Repealed]

§ 50009. Medi-Cal Consultant.

Medi-Cal consultant, as used in these regulations, means the appropriate professional individual employed by the Department to render advice and determinations in matters related to services provided under Medi- Cal. Appropriate Medi-Cal consultants shall personally review and sign any document as required by these regulations. Signatory authority of a Medi-Cal consultant shall not be delegated.

§ 50009.1. Medical Review.

(a) Medical review means a periodic, not less than annual, evaluation of the health needs of each beneficiary in each mental hospital, skilled nursing facility and intermediate care facility. Medical Review is conducted by a Medical Review Team on behalf of the Department.

(b) Such review is to determine the quality and adequacy of the services being provided each beneficiary, the level of care required to meet each beneficiary's health needs and the necessity and desirability of the initial or continued placement of such patient in such facility.

(c) The review shall include a personal contact with and observation of each beneficiary and a review of each beneficiary's medical record by a Team member or members. The review may include a medical examination of the beneficiary by the Medi-Cal consultant when the consultant deems it necessary.

§ 50009.2. Medical Review Team.

A Medical Review Team shall be comprised of a physician and other appropriate health and social service personnel necessary to conduct medical review.

§ 50009.3. Health Care Services.

Health care services means the medical services, social services, supplies, devices, drugs and any other medical care to which an eligible person is entitled pursuant to these regulations.

§ 50011. Definitions -General.

The definitions in this article shall apply to Chapter 2 of this division unless the context requires otherwise.

§ 50012. Abbreviations.

The following abbreviations shall apply to chapter 2 of this division:

ABD.
Aged, Blind or Disabled.
ABD-MN.
Aged, Blind or Disabled -Medically Needy.
AFDC.
Aid to Families with Dependent Children.
AFDC-MN.
Aid to Families with Dependent Children - Medically Needy.
BRU.
Benefits Review Unit.
CETA.
Comprehensive Employment and Training Act.
CHDP.
Child Health and Disability Prevention Program.
EAS.
Eligibility and Assistance Standards Manual.
ETS.
Employment Training Services.
HIC.
Social Security Health Insurance Claim Number.
INS.
Immigration and Naturalization Service.
LTC.
Long-Term Care.
MBSAC.
Minimum Basic Standard of Adequate Care.
MFBU.
Medi-Cal Family Budget Unit.
MI.
Medically Indigent.
MN.
Medically Needy.
OASDI.
Old Age Survivors and Disability Insurance.
Other PA.
Other Public Assistance.
PA.
Public Assistance.
PCCM.
Primary Care Case Management.
PHP.
Prepaid Health Plan.
POE.
Proof of Eligibility.
SDX.
State Data Exchange.
SSN.

Social Security Number.
SSI/SSP.
Supplemental Security Income/State Supplemental Program.
UIB.
Unemployment Insurance Benefits.
WIN.
Work Incentive Program.

§ 50013. Adequate Consideration.

Adequate consideration means the receipt of cash or property which is fair and reasonable under the circumstances considering the net market value of property that is sold, converted or transferred.

§ 50014. Adult.

(a) Adult means:

(1) A person who is 21 years of age or older.

(2) A blind or disabled MN person who is 18 to 21 years of age, living in the home of a parent and not currently enrolled in school, college, university, or a course of vocational or technical training to prepare him/her for gainful employment.

(3) A person who is 18 to 21 years of age, who is not living in the home of a parent or caretaker relative, is not claimed as a tax dependent of his/her parent(s) and is not receiving out-of-home care from a public agency.

(4) A person 14 to 18 years of age who is not living in the home of a parent or caretaker relative and who does not have a parent, caretaker relative or legal guardian handling any of his/her financial affairs.

§ 50015. Adverse Action.

(a) Adverse action means an action taken by a county department which discontinues Medi-Cal eligibility or increases an MFBU's share of cost. The following shall not be considered to be adverse actions:

(1) Discontinuance due to any of the following reasons:

(A) Death, for a one-person MFBU.

(B) The whereabouts of the beneficiary is unknown and the post office has returned county department mail directed to the beneficiary indicating no forwarding address.

(C) Admission to an institution which renders the beneficiary ineligible.

(D) The beneficiary also has Medi-Cal eligibility under another identity or category, or in another county or state; or will have such dual eligibility as of the first of the coming month if discontinuance action is not taken.

(E) Receipt of the beneficiary's clear and signed written statement that does either of the following:

1. States the beneficiary no longer wishes Medi-Cal benefits.

2. Gives information that requires discontinuance and includes the beneficiary's acknowledgment that this must be the consequence of supplying such information.

(2) An increase in an MFBU's share of cost due to either of the following:

(A) The voluntary inclusion of eligible family members who currently are not receiving benefits under any Medi-Cal program.

(B) Receipt of the beneficiary's clear and signed statement which gives information which requires an increase in the share of cost and includes the beneficiary's acknowledgment that this must be the consequence of supplying such information.

§ 50016. Aid.

Aid means cash assistance, food stamps or Medi-Cal.

§ 50017. Aid Category.

Aid category means the specific category under which a person is eligible to receive Medi-Cal.

§ 50018. Aid Code.

Aid code means the two-digit number which indicates the aid category under which a person is eligible.

§ 50019. Aid to Families with Dependent Children (AFDC).

Aid to Families with Dependent Children (AFDC) means the public assistance program that provides a cash grant and Medi-Cal to children deprived of parental support or care and their eligible relatives.

§ 50020. Aid to the Potentially Self-Supporting Blind (APSB). [Repealed]

§ 50021. Applicant.

Applicant means the individual or family making, or on whose behalf is made, an application, request for restoration of aid or reapplication.

§ 50022. Application.

Application means a written request for aid.

§ 50023. Approval of Eligibility.

Approval of eligibility means the determination made by the county department that a person or family is eligible for Medi-Cal.

§ 50024. Beneficiary.

Beneficiary means a person who has been determined eligible for Medi-Cal.

§ 50025. Benefits Review Unit (BRU). [Repealed]

§ 50025.3. Board and Care.

(a) Board and care means receipt of board, room, personal care and designated supplemental services related to individual needs in one of the following nonmedical protective living environments certified in accordance with EAS 46-325.3 for a full calendar month:

(1) A licensed residential care facility.

(2) The home of a relative or legally appointed guardian or conservator, other than the home of a spouse or the home of a parent for a blind or disabled child.

(3) A home in which a child is placed by a court under Welfare and Institutions Code 727(a).

(4) An exclusive use home approved by a licensed home finding agency.

§ 50025.5. Burial Insurance.

Burial insurance means insurance which by its terms can only be used to pay the burial expenses of the insured.

§ 50025.6. California Standard Nomenclature (CSN), 1979. [Repealed]

§ 50026. Cash Grant.

Cash grant means the money payment made to a person eligible for AFDC, EVH or SSI/SSP.

§ 50027. Certification Date for Claims Clearance.

Certification date for claims clearance means the date of the most recent service listed on the Record of Health Care Costs, MC 177S or MC 177P.

§ 50028. Certification -Effective Date.

Effective date of certification for Medi-Cal means the date the person is certified to receive Medi-Cal benefits.

§ 50029. Certification for Medi-Cal.

Certification for Medi-Cal means the determination by the county department or the Department that a person is eligible for Medi-Cal and has no share of cost, has met the share of cost or is in long-term care and has a share of cost which is less than the cost of long-term care at the Medi-Cal rate.

§ 50029.5. Certified Long-Term Care Insurance Policy or Certificate.

Certified Long-Term Care Insurance Policy or Certificate means any long-term care insurance policy or certificate certified by the Department of Health Services and approved for issue or delivery to California residents by the Department of Insurance as meeting the requirements set forth in Section 22005(e) of the Welfare and Institutions Code.

§ 50030. Child.

(a) Child means a person under the age of 21 except for those persons who are specified as adults in Section 50014.

(b) An unborn is considered a child for Medi-Cal purposes.

§ 50031. Child Health and Disability Prevention Program (CHDP).

Child Health and Disability Prevention Program (CHDP) means the community based program for early identification and referral for treatment of persons under 21 years of age with potentially handicapping conditions.

§ 50032. Competent.

Competent means being able to act on one's own behalf in business and personal matters.

§ 50033. Contiguous Property.

Contiguous property means adjacent or adjoining property that is not separated by a road, street, right of way or in any other manner from property being considered.

§ 50034. Conversion of Property.

Conversion of property means changing property from one form to another without changing ownership.

§ 50035. County Agency.

County agency means either an administrative division of a county government or a noncounty organization that has a contract with the county to act on the county's behalf.

§ 50035.5. County Cash-Based Medi-Cal Eligibility.

County cash-based Medi-Cal eligibility means eligibility for Medi-Cal benefits which is based upon a county department determination of eligibility for a cash grant.

§ 50036. County Department.

County department means the department authorized by the county board of supervisors to administer aid programs, including Medi-Cal.

§ 50036.5. County Case Error Rate.

The county case error rate means the number of quality control case reviews found in error divided by the total number of completed case reviews in that county, exclusive of state caused errors.

§ 50036.6. Dependent Relative. [Repealed]

§ 50037. Eligibility and Assistance Standards Manual (EAS).

Eligibility and Assistance Standards Manual (EAS) means the portion of the Manual of Policies and Procedures published by the State Department of Benefit Payments which includes regulations pertaining to the AFDC, APSB, SSP and EVH programs.

§ 50037.5. Eligibility Quality Control.

(a) Eligibility quality control means both of the following:

(1) Federally mandated review of Medi-Cal cases to ensue proper determination of eligibility.

(2) State mandated review of Medi-Cal cases within individual counties to ensure proper determination of eligibility.

§ 50038. Eligibility Services.

Eligibility services means those services provided by the county department relating to the initial and continuing determination of a person's or family's Medi-Cal eligibility.

§ 50038.5. Emergency Assistance (EA).

(a) Emergency Assistance (EA) means the public assistance programs that provide assistance for 30 days to:

(1) Families not meeting the qualifications for the federal AFDC-U program.

(2) Those children who are being, or are in immediate danger of being abused, neglected or exploited and to families of such children.

§ 50039. Encumbrances of Record.

Encumbrances of record means obligations for which property is security, as evidenced by a written document.

§ 50040. Fair Market Value. [Repealed]

§ 50041. Family Member.

(a) Family member means the following persons living in the home:

(1) A child or sibling children.

(2) The parents married or unmarried of the sibling children.

(3) The stepparents of the sibling children.

(4) The separate children of either unmarried parent or of the parent or stepparent.

(b) If there are no children, family member means a single person or a married couple.

§ 50041.5. Federal Poverty Level.

The federal poverty level means an income level based on the official poverty line as defined by the federal Office of Management and Budget and revised annually or at any shorter interval the Secretary of Health and Human Services deems feasible and desirable pursuant to Section 9902(2), Title 42, United States Code.

§ 50042. Foster Child. [Repealed]

§ 50043. Heirloom.

Heirloom means any item of personal property, other than cash and securities, which has substantially sentimental value, has been owned by a family for at least two generations and is intended to be retained by the family in succeeding generations.

§ 50044. Home.

Home means real or personal property, fixed or mobile, located on land or water, in which a person or family lives.

§ 50045. Immigration and Naturalization Service (INS).

Immigration and Naturalization Service (INS) means the branch of the United States Government that administers regulations regarding aliens in the United States.

§ 50045.1. Impairment Related Work Expenses (IRWE).

“Impairment Related Work Expenses” (IRWE) means those expenses of a working disabled QMB or SLMB program applicant/beneficiary which are necessary to become or remain employed. Such expenses include but are not limited to expenses which are:

(a) Required to control a disabling condition, thereby enabling the individual to work;

(b) Essential to meet the functional demands of a job, e.g., wheelchairs, respirators, prosthesis, attendant care;

(c) Necessary in preparing for work, in traveling to and from work, or assistance needed immediately upon returning from work (e.g., attendant care services, transportation costs, exterior ramps, and railing or pathways modified to the exterior of the applicant's/beneficiary's residence).

§ 50045.3. Income and Eligibility Verification System.

The Income and Eligibility Verification System (IEVS) is the federally mandated system established to obtain, use and verify information relevant to determination of eligibility and share of cost.

§ 50045.5. In-Home Supportive Services.

In-Home Supportive Services (IHSS) means the social services program which provides necessary personal and domestic care so that aged, blind and disabled persons may remain in their own homes.

§ 50046. Inmate.

Inmate means a person living or being cared for in an institution. Excluded from this definition are persons residing at a facility for vocational training or educational purposes, and persons temporarily in an institution pending more suitable arrangements, such as children in a local agency facility pending foster care placement.

§ 50047. Institution.

Institution means an establishment which provides food and shelter to four or more persons unrelated to the proprietor and in addition provides some treatment or services which meet needs beyond the basic provision of food and shelter.

§ 50048. Institution -Medical.

Medical institution means any public or private acute care hospital, acute psychiatric hospital, intermediate care facility, skilled nursing facility, or other medical facility licensed by an officially designated state standard setting authority.

§ 50049. Institution -Mental Diseases.

An institution for mental diseases means an institution primarily engaged in providing diagnosis, treatment or care for persons with mental illness.

§ 50050. Institution -Nonmedical.

Nonmedical institution means any institution providing nonmedical residential care, custodial care, custody or restraint. This includes penal institutions.

§ 50051. Institution - Private.

A private institution means a proprietary or nonprofit facility managed and controlled by an individual, private association or corporation.

§ 50052. Institution - Public.

Public institution means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. Excluded from this definition are medical facilities and publicly operated community residences designed to serve and serving no more than sixteen persons.

§ 50052.5. Institution - Tuberculosis.

Tuberculosis institution means an institution which is primarily engaged in providing diagnosis, treatment or care of persons with tuberculosis, including medical attention, nursing care and related services.

§ 50053. Intraprogram Status Change.

Intraprogram status change means a change in a person's or family's eligibility from one aid category to another aid category, in which the first digit of the aid code remains the same.

§ 50054. Interprogram Transfer.

Interprogram transfer means a transfer of eligibility from one aid category to another aid category, in which the first digit of the aid code changes.

§ 50054.5. Life Insurance.

Life insurance means a contract for which premiums are paid during the lifetime of the insured, and on which the insuring company pays the face amount of the policy to the beneficiary upon the death of the insured. Life insurance may also be purchased by a single premium or by letting dividends accumulate.

§ 50054.7. Limited Service Status.

Limited service status means that the beneficiary's use of the Medi-Cal card is limited because of enrollment in a noncomprehensive PHP or PCCM plan, improper utilization of service, application as a child under Section 50147.1 or participation in a pilot project conducted by the Department.

§ 50055. Linked.

Linked means meeting the SSI/SSP requirements of age, blindness or disability or the AFDC requirements of deprivation of parental support or care.

§ 50056. Long-Term Care (LTC).

Long-term care (LTC) means inpatient medical care which lasts for more than the month of admission and is expected to last for at least one full calendar month after the month of admission.

§ 50057. Marriage.

Marriage means the state of being married, including a legal common law marriage, as defined in Section 4100 et seq., Chapter 2, Division 4, Part 5, Title 1, California Civil Code.

§ 50058. Medi-Cal.

Medi-Cal means California's medical assistance program and the benefits available under that program.

§ 50059. Medi-Cal Card.

Medi-Cal card means a computer printed or hand typed card issued each month to a person certified to receive Medi-Cal in order to identify the person as a Medi-Cal beneficiary and authorize the receipt of Medi-Cal covered services by that person.

§ 50059.5. State Dollar Error Rate.

The state dollar error rate means the Medicaid dollar error rate reported to the Department by the United States Department of Health and Human Services, less any portion of this error rate attributable to state caused errors.

§ 50059.6. Federal Standard.

“Federal standard” means the Medicaid dollar error rate standard to which the State is held accountable by the Federal Government.

§ 50059.7. State Caused Errors.

State caused errors means case errors in a county for which the state assumes responsibility.

§ 50060. Medi-Cal Family Budget Unit (MFBU).

Medi-Cal Family Budget Unit (MFBU) means the persons who will be included in the Medi-Cal eligibility and share of cost determination.

§ 50060.5. Medi-Cal-Only Eligibility.

Medi-Cal-only eligibility means a person's or family's eligibility for Medi-Cal benefits that has been determined independently of an eligibility determination for any other aid or benefit program.

§ 50060.6. Medical Support.

Medical support is any liability or payment for the purpose of medical care available under a court or administrative order, including but not limited to health insurance, specific dollar amounts for medical purposes, and payments for medical care from any third party.

§ 50061. Medically Indigent (MI) Person or Family.

Medically indigent (MI) person or family means a person or family eligible under the Medically Indigent program.

§ 50062. Medically Needy (MN) Person or Family.

Medically needy (MN) person or family means a person or family eligible under the Medically Needy program.

§ 50063. Minimum Basic Standard of Adequate Care (MBSAC).

Minimum Basic Standard of Adequate Care (MBSAC) means the amount necessary to provide an AFDC family with basic needs as specified in the EAS manual.

§ 50063.5. Minor Consent Services.

(a) Minor consent services means services related to:

(1) Sexual assault.

(2) Drug or alcohol abuse for children 12 years of age or older.

(3) Pregnancy.

(4) Family planning.

(5) Venereal disease for children 12 years of age or older.

(6) Sexually transmitted diseases designated by the Director for children 12 years of age or older.

(7) Mental health care for children 12 years of age or older who are mature enough to participate intelligently and which is needed to prevent the children from seriously harming themselves or others or because the children are the alleged victims of incest or child abuse.

§ 50064. Multiple Dwelling Unit.

Multiple dwelling unit means any dwelling with more than one separate living unit, that is, a unit which normally would include as a minimum a bathroom and a kitchen.

§ 50064.5. Nonrecurring Lump Sum Payment.

Nonrecurring lump sum payment means a payment accrued over more than one calendar month and not expected to be received again in the future. It does not include the amount of the monthly benefit normally attributable to the month for which eligibility is being determined.

§ 50065. Obligate.

Obligate means to incur a cost for health care services.

§ 50066. Other Public Assistance (Other PA) Recipient.

Other Public Assistance (Other PA) recipient means a person eligible for Medi-Cal under one of the categories in the Other Public Assistance program.

§ 50067. Overpayment.

Overpayment means the receipt of Medi-Cal benefits when there is no entitlement to all or a portion of the benefits received.

§ 50068. Parent.

Parent means the natural or adoptive parent of a child.

§ 50068.5. Parent - Minor.

Minor parent means a person who meets the definition of a child and has his or her own child or children living in the home.

§ 50069. Parents - Unmarried.

Unmarried parents means parents who are living together with their common child and the parents are not married to each other.

§ 50069.5. Parent - Unmarried Minor. [Repealed]

§ 50070. Patient.

Patient means a person receiving individual professional services directed by a licensed practitioner of the healing arts towards maintenance, improvement, or protection of health, or the alleviation of disability or pain.

§ 50071. Persons Living in the Home.

(a) Persons living in the home means all of the following:

(1) Persons physically present in the home;

(2) Persons temporarily absent from the home because of hospitalization, visiting, vacation, trips in connection with work, or because of similar reasons as limited by (d).

(3) Persons away at school or vocational training who will resume living in the home as evidenced by the person returning home for vacations, weekends and at other times.

(b) A temporary absence is normally one in which the person leaves and returns to the home in the same month or the following month.

(c) Whether a person is living in the home while in LTC or board and care shall be determined in accordance with Section 50377.

(d) A child, other than specified in (e), temporarily absent from the home in accordance with (a)(2) shall be considered to be living in the home as long as the parent continues to have responsibility for the care and control of the child. A parent continues to have responsibility for the care and control of a child until the court removes this responsibility or the parent voluntarily relinquishes it in accordance with Department of Social Services, Manual of Policies and Procedures, Division 30.

(e) The home in which a child shall be determined in accordance with Section 50374 when both of the following conditions exist:

(1) The child stays alternately for periods of one month or less with each of his/her parents.

(2) The child's parents are separated or divorced.

(f) An 18 to 21 year old or unmarried minor parent living on the parent's property shall not be considered to be living in the parent's home if both of the following conditions exist:

(1) The 18 to 21 year old or unmarried minor parent does not receive any support from the parents.

(2) The building the 18 to 21 year old or unmarried minor parents lives in would be considered other real property of the parents.

(g) A person whose institutional status results in ineligibility for Medi-Cal shall not be considered to be living in the home during any full month of institutionalization.

§ 50071.5. Prepaid Health Plan.

(a) Prepaid health plan means any health care service plan as defined in Health and Safety Code Section 1345 (f) which:

(1) Is licensed as a health care service plan by the Commissioner of Corporations pursuant to the Knox-Keene Health Care Service Plan Act of 1975, Chapter 2.2, commencing with Section 1340, Division 2, Health and Safety Code, or has an application for licensure pending and was registered under the Knox-Mills Health Plan Act prior to its repeal in Chapter 941, Statutes of 1975.

(2) Meets the requirements for participation in the Medicaid Program, Title XIX of the Social Security Act, on an at risk basis.

(3) Has a contract with the Department to furnish directly or indirectly health services to Medi-Cal beneficiaries on a predetermined periodic rate basis.

(b) The term “prepaid health plan” does not include any pilot program contract entered into pursuant to Article 7, commencing with Section 14490, Chapter 8, Part 3, Division 9, Welfare and Institutions Code.

§ 50071.6. Prepaid Health Plan -Comprehensive.

Comprehensive prepaid health plan means a prepaid health plan that is required by contract with the Department to provide the full scope of benefits available under the Medi-Cal program.

§ 50071.8. Primary Care Case Management (PCCM) Plan.

Primary care case management plan or PCCM plan means any person or organization who:

(a) Has entered into a contract with the Department on a capitated or risk sharing basis, or both, to provide or arrange for the provision of health care services under the provisions of Article 2.9 commencing with section 14088, Welfare and Institutions Code; and

(b) Meets the requirements for participation in the Medicaid Program, as stated in Title XIX of the Social Security Act, on an at-risk basis.

§ 50072. Property - Community.

Community property means property acquired by either spouse during marriage, unless the property was acquired as separate property or with funds that can be identified as separate property.

§ 50073. Property - Personal.

Personal property means possessions or interests, exclusive of real property, that may be easily transported or stored; including but not limited to cash on hand, bank accounts, notes, mortgages, deeds of trust, cash surrender value of life insurance, motor vehicles, uncollected judgments, an interest in a firm in receivership, a lawsuit, patents and copyrights.

§ 50074. Property - Real.

Real property means land and improvements which generally includes any immovable property attached to the land and any oil, mineral, timber or other rights related to the land.

§ 50075. Property - Separate.

(a) Separate property means any item that is considered separate property under California Property Law. Generally, separate property is property acquired by an individual by any method prior to marriage, after obtaining an interlocutory or final judgment of dissolution, or while voluntarily separated; or at any time by gift or inheritance, or purchases made with funds that are separate property or with funds from the sale of separate property.

(b) Separate property also includes that portion of a couple's former community property which has been transmuted into separate property by a written interspousal agreement in accordance with 50403(c).

§ 50076. Property - Share of Community.

For the purpose of determining Medi-Cal eligibility, share of community property is to be treated as if each spouse owns one-half of the community property.

§ 50077. Public Agency.

Public agency means an administrative division of local, state or federal government, or an organization that has a contract to act in behalf of the local, state or federal government.

§ 50078. Public Assistance (PA) Recipient.

Public assistance (PA) recipient means a person or family receiving assistance under the AFDC, SSI/SSP, Indochinese refugee or Cuban refugee program.

§ 50079. Public Funds.

Public funds means monies provided by local, state or federal government.

§ 50079.5. Publicly Operated Community Residence.

(a) Publicly operated community residence means a facility designed and planned to serve no more than 16 residents which is actually serving 16 or fewer residents. The facility provides food and shelter and must provide some additional services such as:

(1) Social services.

(2) Help with personal activities.

(3) Training in socialization and life skills.

(b) Excluded from this definition are:

(1) Residential facilities located on the grounds or immediately adjacent to any large institution or multi-purpose complex.

(2) Educational or vocational training facilities.

(3) Correctional or holding facilities for persons detained under the penal system.

(4) Medical treatment facilities.

§ 50079.6. Qualified Disabled and Working Individual.

“Qualified Disabled and Working Individual” means an individual who meets the eligibility criteria for the Qualified Disabled and Working Individual program specified in Section 50256.

§ 50079.7. Qualified Medicare Beneficiary.

“Qualified Medicare Beneficiary” means an individual who meets the eligibility criteria for the Qualified Medicare Beneficiary program specified in Section 50258.

§ 50080. Quality Control. [Repealed]

§ 50081. Reapplication.

Reapplication means an application for Medi-Cal-only eligibility made in the same county as a previous application, if the previous application was denied or withdrawn, or Medi-Cal-only eligibility based on the previous application has been discontinued for more than 12 months.

§ 50082. Recipient.

Recipient means a person or family receiving aid under a public assistance program or the Other Public Assistance program.

§ 50083. Redetermination.

Redetermination means the review of a person's or family's Medi-Cal eligibility.

§ 50084. Relative.

Relative means a mother, father, grandfather, grandmother, son, daughter, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, niece, half-brother, half-sister, any such person of a preceding or succeeding generation denoted by a prefix of grand, great or great-great or the suffix in-law.

§ 50085. Relative - Caretaker.

Caretaker relative means a relative who provides care and supervision to a child, if there is no natural or adoptive parent in the home.

§ 50086. Repayment.

Repayment means the liquidation of an overpayment in response to issuance of demands and recovery thereof by the Department of Benefit Payments.

§ 50087. Residence.

Residence means the place in which a person or family lives or is physically present if the person or family has no present intention of leaving.

§ 50088. Responsible Relative.

Responsible relative means a relative who is responsible to contribute to the cost of health care services received by a Medi-Cal beneficiary.

§ 50089. Restoration.

Restoration means the approval of Medi-Cal-only eligibility for a person or family in the same county as that in which they were previously eligible for Medi-Cal-only, if the effective date of the approval occurs within 12 months of the end of the previous period of eligibility.

§ 50090. Share of Cost.

Share of cost means a person's or family's net income in excess of their maintenance need that must be paid or obligated toward the cost of health care services before the person or family may be certified and receive Medi-Cal cards.

§ 50091. Share of Encumbrances.

Share of encumbrances means that portion of the encumbrances attributed to each portion of jointly owned property.

§ 50091.5. Specified Low-Income Medicare Beneficiary.

“Specified Low-Income Medicare Beneficiary” (SLMB) means an individual who meets the eligibility criteria for the SLMB Program specified in Section 50258.1.

§ 50092. Spenddown. [Repealed]

§ 50093. State Data Exchange (SDX).

State Data Exchange (SDX) means the data system by which the Federal Government provides information to the State regarding the eligibility of SSI/SSP applicants and recipients.

§ 50094. Stepparent.

Stepparent means a person who is married to the parent of a child and who is not the other parent of the child.

§ 50095. Supplemental Security Income/State Supplemental Program (SSI/SSP).

Supplemental Security Income/State Supplemental Program (SSI/SSP) means the federal and state payments, respectively, which are based on need, and are paid to aged, blind or disabled persons.

§ 50095.1. Title II Disregard Person.

§ 50095.5. Therapeutic Wages.

(a) Therapeutic wages are wages earned by the individual when all of the following conditions are met:

(1) A physician who does not have a financial interest in the long-term care facility in which the individual resides, and who is in charge of the individual's case prescribes this work as therapy for the individual.

(2) The individual must be employed by the same long-term care facility in which he or she resides.

(3) The individual's employment does not displace any existing employees.

(4) The individual has resided in a long-term care facility continuously since September 1979.

§ 50095.7. Title II Disregard Person.

“Title II disregard person” means a person who meets all the conditions of Section 50564.

§ 50096. Transfer of Property.

Transfer of property means a change in ownership whereby a person no longer holds title to, or beneficial interest in, property.

§ 50097. Verification.

Verification means the process of obtaining acceptable evidence which substantiates statements made by an applicant/beneficiary.

§ 50101. County Department Responsibilities.

(a) The county department shall:

(1) Be responsible for determining initial and continuing eligibility for Medi-Cal applicants or beneficiaries promptly and humanely, in accordance with:

(A) Medi-Cal regulations.

(B) Departmental directives.

(2) Construe Medi-Cal regulations fairly and equitably when determining Medi-Cal eligibility.

(3) Have available at each office copies of all laws, rules, regulations and bulletins relating to Medi-Cal.

(4) Comply with state hearing decisions of the Director.

(5) Assist applicants or beneficiaries in understanding their rights and responsibilities in relation to application for Medi-Cal.

(6) Evaluate the capacity of the applicants or beneficiaries to discharge their responsibilities as set forth in these regulations.

(7) Assist applicants or beneficiaries as needed in establishing their eligibility.

(8) Determine eligibility, assess need, and authorize personal care program services for eligible beneficiaries, as needed.

(b) The county department shall take the following actions whenever an applicant or beneficiary, who is applying for or receiving Medi-Cal on behalf of a child under eighteen years of agewho was born out of wedlock or who has an absent parent, meets his/her responsibilities as specified in Section 50185 (a) 10.

(1) As soon as possible after the applicant's or beneficiary's opportunity to claim good cause as specified in 50771.5, and not later than two working days after approval of eligibility, the county shall provide to the district attorney the following forms, whether or not the Child/Spousal and Medical Support Notice and Agreement (CA 2.1 Notice and Agreement) has been completed;

(A) A completed Referral to District Attorney (CA 371, Revised December 1992)

(B) A Child Support Questionnaire (CA 2.1 Q Support Questionnaire, Revised March 1993), if one has been completed;

(C) Health Insurance Questionnaire (DHS 6155, Revised October 1990), if one has been completed.

(D) Any other forms or information requested by the district attorney.

(2) If the referral described in (1) above has previously been provided to the district attorney, the county shall promptly report to the district attorney whenever good cause has been claimed. The district attorney will suspend all activities to establish paternity or secure medical support until notified of a final determination of good cause by the county.

(3) The county shall promptly report to the district attorney all cases in which it has been determined that there is or is not good cause for refusal to cooperate as specified in Section 50771.5. The district attorney will not undertake to establish paternity or secure support if there has been a finding of good cause unless there also has been a determination by the county that the district attorney may proceed without the

participation of the parent or caretaker relative. If there has been such a determination, the district attorney may undertake to establish paternity or secure support but may not involve the parent or caretaker relative.

(4) If the county determines that the applicant or beneficiary and the child on whose behalf the application was filed are not eligible, the applicant or beneficiary shall be informed that he/she may go to the district attorney for help in locating the absent parent(s) of the child, collecting child and medical support for the child, and establishing paternity.

(5) The county shall provide the district attorney with any information requested concerning medical support cases and shall advise the district attorney in writing if any of the following circumstances arise:

(A) A person is added to or deleted from the MFBU.

(B) The child ceases living with the person who is receiving Medi-Cal on his/her behalf.

(C) A child moves out of foster care and begins living with a parent or relative.

(D) A child has been accepted for adoption by a public or private adoption agency or such an acceptance has been terminated.

(E) Medi-Cal benefits have been discontinued.

(6) If the district attorney notifies the county that the applicant or beneficiary has not cooperated, the county shall verify the facts, determine whether he/she had good cause for failure to cooperate pursuant to Section 50771.5, and notify the district attorney of the determination.

(7) Prior to making a final determination of good cause for refusing to cooperate, the county shall:

(A) Afford the district attorney the opportunity to review and comment on the findings and basis for the proposed determination;

(B) Consider any recommendation from the district attorney; and from any witnesses on behalf of the applicant in any hearing that results from an applicant's or beneficiary's appeal of any county action relating to establishing paternity or securing medical support.

§ 50103. Civil Service or Merit Systems.

All persons employed by a county and engaged in administration of the Medi-Cal program shall be employed under a civil service or merit system that meets the requirements established by the California State Personnel Board.

§ 50105. Staffing Requirements.

(a) Medi-Cal eligibility services may be provided by personnel in those technical nonsocial work job classifications that are established by the county personnel agency responsible for approving such job classification.

(b) The county department shall assign Medi-Cal eligibility staff in sufficient numbers so that any applicant or beneficiary in need of eligibility services shall be provided with those services.

(c) Eligibility information shall be available 24 hours a day, 7 days a week, to persons with medical and related emergencies.

§ 50106. Staff Training.

The county department shall train Medi-Cal eligibility staff in accordance with the training requirements of Division 14, Manual ofPolicies and Procedures, Department of Social Services.

§ 50107. Civil Rights.

(a) The county department shall not discriminate against any applicant or beneficiary on the basis of race, color, creed, ethnic origin, sex, marital status, age, physical or mental handicap, national origin or political affiliation.

(b) Persons who believe that they have been discriminated against may file a grievance with the Department in accordance with departmental procedures.

§ 50109. Reports.

The county department shall submit reports as required by the Department and shall comply with such provisions as the Department may find necessary to ensure the correctness of the reports.

§ 50110. Medi-Cal Case.

(a) Each MFBU shall be one Medi-Cal case.

(b) Each Other PA person or Other PA family group shall be one Medi-Cal case.

(c) A PA recipient or PA family group shall not be a Medi-Cal case.

§ 50111. Case Records and Confidentiality.

(a) The county department shall adhere to the requirements in Divisions 19 and 23, Manual of Policies and Procedures, Department of Social Services, governing:

(1) Maintenance of case records.

(2) Confidentiality of case records.

(3) Safeguarding federal tax information.

(4) Access to case records.

(b) The board of supervisors of a county may authorize the destruction of:

(1) Narrative portions of a case record which are over three years old in any case file, active or inactive, after audit by the county department.

(2) Case files which have remained inactive for a period of three years providing the Department has not notified the county department that unresolved issues or pending civil or criminal actions exist.

§ 50113. Forms.

(a) The county department shall use the forms prescribed by the Department in providing Medi-Cal eligibility services.

(b) Other forms shall not be substituted by the county department unless specifically approved by the Department.

§ 50115. Quality Control -County Cooperation.

The county department shall cooperate with the Department in ensuring that federal quality control requirements are met.

§ 50116. Medi-Cal Fiscal Penalties.

(a) The Department shall assess fiscal penalties to counties whenever the state dollar error rate exceeds the federal standard.

(b) A county's case error rate shall be determined based on reviews by Department staff of a random sample of a minimum number of cases for each period, as follows:

(1) All cases shall be sampled in any county with less than 50 Medi-Cal cases.

(2) Fifty cases in any county with greater than 0.01 percent and less than or equal to 0.50 percent of the Medi-Cal cases in the state.

(3) Seventy-five cases in any county with greater than 0.50 percent and less than or equal to 1.0 percent of the Medi-Cal cases in the state.

(4) One hundred cases in any county with greater than 1.0 percent and less than or equal to 3.0 percent of the Medi-Cal cases in the state.

(5) One hundred twenty-five cases in any county with greater than 3.0 percent and less than or equal to 10.0 percent of the Medi-Cal cases in the state.

(6) Six hundred fifty cases in any county with greater than 10.0 percent of the Medi-Cal cases in the state.

(c) Medi-Cal fiscal penalties established under this Section shall apply only to those counties for which case error rates are established.

(d) The Department shall determine which counties in the state are liable for fiscal penalties as follows:

(1) The 60 percent of counties in the state with the highest case error rates shall be liable if the state's dollar error rate exceeds the federal standard by 0.01 percent to 1.0 percent.

(2) The 70 percent of counties in the state with the highest case error rates shall be liable if the state's dollar error rate exceeds the federal standard by greater than 1.0 percent and less than or equal to 2.0 percent.

(3) The 80 percent of counties in the state with the highest case error rates shall be liable if the state's dollar error rate exceeds the federal standard by greater than 2.0 percent and less than or equal to 3.0 percent.

(4) The 90 percent of counties in the state with the highest case error rates shall be liable if the state's dollar error rate exceeds the federal standard by greater than 3.0 percent and less than or equal to 4.0 percent.

(5) All counties in the state shall be liable if the state's dollar error rate exceeds the federal standard by greater than 4.0 percent.

§ 50116.5. Appeal of Quality Control Review Findings.

(a) When the Department finds a sampled case that includes an ineligible person or a person with an understated share of cost, written notification which describes the error shall be sent to the county department.

(b) The county department shall respond to the Department in writing within two weeks from receipt of notification of the error and shall indicate whether it agrees or disagrees with the findings.

(c) If the county disagrees, the Department shall reevaluate the error findings, taking into consideration any additional facts contained in the county's response.

(d) The Department shall again notify the county of the Department's findings.

(e) The county may then appeal to the Chief, Medi-Cal Policy Division, requesting that the Department review the case and render a final decision.

§ 50117. Calculation of Medi-Cal Fiscal Penalties.

(a) The Department shall calculate the fiscal penalty for a liable county for each monitoring period as follows:

(1) A penalty multiple shall be calculated by multiplying a county's case error rate times its percentage of statewide Medi-Cal cases.

(2) A county's penalty multiple shall be divided by the sum of the penalty multiples of all counties then multiplied times the penalty bank.

(b) The penalty bank shall include only quality control federal fiscal sanctions, federal withholds, federal disallowances, and any associated General Fund expenditures, minus the value of any state assumed errors and the General Fund share of the value of client caused errors.

(c) The case error rate and penalty multiple shall be adjusted by excluding client errors for the purpose of determining the associated General Fund expenditures.

(d) If the Federal Government reduces or eliminates any quality control federal fiscal sanction, federal withhold or federal disallowance assessed a county as a penalty, the Department shall reduce or eliminate the corresponding fiscal penalty assessment including any associated General Fund expenditures to liable counties.

(e) The monitoring period shall be the federal fiscal year. Fiscal penalties shall apply to the entire monitoring period. The first monitoring period shall begin October 1, 1988.

§ 50118. Application of Medi-Cal Fiscal Penalties.

(a) The Department shall notify the county in writing when it determines that a Medi-Cal fiscal penalty will be imposed.

(b) The county may request reconsideration of the Medi-Cal fiscal penalty in accordance with Section 50118.5.

(c) When a Medi-Cal fiscal penalty is imposed, the amount of the penalty shall be collected through direct repayment.

§ 50118.5. Reconsideration of a Medi-Cal Fiscal Penalty.

(a) A county may request reconsideration of a Medi-Cal fiscal penalty if the county case error rate is caused by circumstances outside the control of the county. Such circumstances may include, but are not necessarily limited to, the following:

(1) Natural disasters which contribute significantly to the county case error rate.

(2) Work stoppages or other work activity beyond the control of the county which has a significant adverse impact on the processing of Medi-Cal eligibility cases.

(3) Failure by the Department to meet the minimum sample of cases specified in Section 50116.

(4) Such other occurrences as determined by the Director.

(b) The county shall have thirty days from the date of the Department's notice of fiscal penalty to file a written request for reconsideration with the Director. The request shall be signed by the county department Director and shall include a concise, detailed explanation of the basis for requesting reconsideration. The Director may, for good cause, extend the time to sixty days for the county to submit a request for reconsideration.

(c) Based on all the available written material, the Director shall address a decision on reconsideration to the county, in writing, within sixty days of receipt of the request.

§ 50119. County Corrective Action Requirements.

(a) The county shall correct a case found in error during the Department's sample case review within thirty days after being notified of the Department's final decision that a case error has occurred.

(b) A county whose case error rate is found to be in excess of fifteen percent shall within 90 days of being notified by the Department of this error rate provide a written report to the Department which shall describe the steps the county has taken or plans to take to reduce or eliminate the causes of error. The Department shall provide direction on the form and content of the report and shall be responsible for approving the county's Corrective Action Plan.

(c) The data collected on an individual county during the review conducted by the Department shall be analyzed by the county to determine causes of error. The county shall utilize this information in conjunction with other information available to the county to develop and implement correction actions which will reduce or eliminate the causes of error.