

Share of Cost	MPP §§30-701(n), 30-701(s)(3), 30-755.31, 30-775	Title 22 CCR §§50603, 50653, 50262, 50501-50571; Pickle Handbook; ACWDL 92-23, 00-57, 00-68, 01-18, etc.
Underpayments	<i>Leach v. Swoap</i> , MPP §30-768.4	Title 22 CCR §50653.3
Beginning Date of Aid	MPP §30-009.231	Title 22 CCR §50197

NEEDS ASSESSMENT

When the issue involves a needs assessment, IHSS regulations apply regardless of whether the case is IHSS residual or PCSP (see Title 22 CCR §51350(a)). In addition, the Medi-Cal program defers to CDSS Adult Programs when there are issues of policy interpretations involving a needs assessment such as generally not allowing for waiting time at the doctor's office as part of medical transportation or not allowing ambulation outside the home.

Judges should contact CDSS Adult Programs for needs assessment issues, including policy interpretations. If the issue involves eligibility, judges should contact Adult Programs if the case is an IHSS residual case and the appropriate Medi-Cal eligibility analyst if the case is a PCSP case.

*California Department of Social Services - State Hearings Division
Notes from the Training Bureau - February 21, 2001*

Item 01-02-02A

Changes in Managed Care Regulations and Clarification of Policies

There were many changes made to Medi-Cal Managed Care regulations involving Two-Plan model counties. These regulation changes are in Barclays California Code of Regulations (CCR) Register 2000 No. 51 dated December 22, 2000.

The regulations that are impacted by these changes are CCR §§53845, 53881, 53886, 53887, 53888, 53889, 53891, 53892 and 53895. The chart below compares the previous regulation and the new regulation for some, but not all of the changes:

Title 22 CCR	Prior to December 19, 2000	Effective December 19, 2000
§53845	This section did not specify that beneficiaries who were enrolled	§53845(e) specifies that beneficiaries enrolled in Medicare HMO, CHAMPUS

	in other health coverage were not to be enrolled in Medi-Cal managed care.	HMO, Kaiser HMO or any other HMO or prepaid plan in which the enrollee is limited to a prescribed panel of providers for comprehensive services shall not be enrolled in a managed care Two-Plan model plan.
§53886	The Health Care Options (HCO), in making its health care options presentation, was required to include much information, but was not required to explain the process for selecting a primary care provider.	The HCO, in making its health care options presentation to each eligible beneficiary, was still required to provide the same information as previously, but under §53886(b)(4), was also required to provide information about the process for selecting or changing a primary care provider and an explanation that beneficiaries have the right to select a primary care provider and to change their primary care provider at any time.
§53887	1. This section was titled "Alternative To Plan Enrollment".	This section is titled "Exemption From Plan Enrollment".
	2. §53887(a) provided that an eligible beneficiary who was receiving fee-for-service Medi-Cal treatment for a complex medical condition requiring continuity of care from a fee-for-service Medi-Cal provider could be exempted from enrollment in a Two-Plan model HMO if the fee-for-service provider was not a contracting provider of either of the two plans in the county. This section did not specify for how long the eligible beneficiary could remain in fee-for service Medi-Cal.	§53887(a) clarifies that the eligible beneficiary may request fee-for service Medi-Cal based upon the exemption for a complex medical condition requiring continuity of care <u>for up to 12 months</u> . §53887(a)(4) adds that any extension of the 12 month medical exemption shall be requested through the HCO program no earlier than 11 months after the starting date of the exemption currently in effect. The HCO is required to notify the beneficiary 45 days before the expiration of the approved exemption and inform the beneficiary how to request an extension. The extension shall be approved if the beneficiary continues to meet the requirements for a medical exemption.
	3. §53887 did not state whether an eligible beneficiary who is	§53887(a)(2)(B) says that "A request for exemption from plan enrollment based on

	already enrolled in a managed care plan could be approved for an exemption from that plan if he/she alleged a complex medical condition that required continuity of care..	complex medical conditions shall not be approved for an eligible beneficiary who has been a member of either plan on a combined basis for more than 90 calendar days or who has begun or was scheduled to begin treatment after the date of plan enrollment."
	4. §53887 referred to exemptions from managed care for a "complex or high risk" medical condition.	§53887 refers to a "complex medical condition."
	5. §53887 listed reasons the department would approve continued fee-for-service Medi-Cal. In addition to a "complex or high risk" medical condition, the department also would approve continued fee-for-service Medi-Cal for an eligible beneficiary if the beneficiary was pregnant, tested positive for HIV or was diagnosed with AIDS, or was participating in a pilot project operated under specified Welfare and Institutions Code (W&IC) sections.	§53887 includes pregnancy, HIV or AIDS and persons who are participating in those specified pilot projects within the definition of a complex medical condition.
		<p>In addition, §53887 added that conditions meeting the criteria for a complex medical condition include, and are similar to, the above stated conditions and the following conditions:</p> <ul style="list-style-type: none"> • Conditions requiring organ transplants • Cancer if the eligible beneficiary is receiving chemotherapy, radiation or other acceptable course of cancer therapy • A major surgical procedure if the eligible beneficiary has been approved by the fee-for-service

		<p>program and is awaiting surgery or is immediately post operative</p> <ul style="list-style-type: none"> • A complex neurological disorder, such as multiple sclerosis, a complex hematological disorder such as hemophilia or sickle-cell anemia, or a complex and/or progressive disorder such as cardiomyopathy or amyotrophic lateral sclerosis that requires ongoing medical supervision • Conditions where an eligible beneficiary is enrolled in a Medi-Cal waiver program that allows treatment at home rather than in a sub-acute, acute, intermediate or skilled nursing facility.
	<p>§53887(b) stated that the department could approve fee-for-service Medi-Cal for any eligible beneficiary whose diagnosis and treatment needs were "verified in writing" by the beneficiary's provider.</p>	<p>§53887(b) provides that exemption from plan enrollment or extension of an approved exemption due to a complex medical condition "shall be requested on the 'Request for Medical Exemption from Plan Enrollment' form (HCO Form 7101, June 2000)".</p>
<p>§53889</p>	<p>§53889 required the HCO to provide for disenrollment on an expedited basis for specified persons such as children receiving services under foster care or adoption assistance, beneficiaries requiring organ transplants and persons inadvertently assigned to the wrong plan. Expedited disenrollment meant processing a request within three days after receipt of the request.</p> <p>Disenrollment requests for persons that were not required to be acted on an expedited basis were to be processed in</p>	<p>§53889 specified that the HCO shall accept and process disenrollment requests, including those submitted by facsimile or telephone, within two working days of receipt if such requests meet the conditions of plan enrollment set out in §53891. §53889(b) sets out specifically what information must be provided on the disenrollment request.</p>

	time to have the disenrollment completed no later than the last day of the calendar month following the disenrollment request.	
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In our discussions with the Managed Care Division, we learned that:

1. Managed Care agrees that if a person in fee-for-service Medi-Cal files a state hearing request prior to the effective date of transfer to a managed care program, that person is entitled to continued fee-for-service coverage until there is an adverse aid pending decision, or an unfavorable decision, whichever comes first.

If there is an aid pending problem, ALJs should contact Scott Richmond or Carmen Romo at (888) 452-8609.

2. There are thousands of notices of action (NOAs) which have been sent, proposing to end fee-for-service benefits and to transfer the beneficiary to managed care. Most are cases that have been sitting dormant for months, but as of February 2001, the Managed Care Division is acting much more promptly to review fee-for-service eligibility.

3. The NOAs do not have a place for the claimant to sign and request a state hearing. The CDHS has agreed to consider revising the NOAs so that the claimants can fill in information to, e.g., request the hearing, authorize a representative, request an interpreter.

*California Department of Social Services - State Hearings Division
Notes from the Training Bureau - February 16, 2001*

Item 01-02-01A

Updated Paraphrased Regulations

This is the February 2001 update of the Paraphrased Regulations (ParaRegs). The last update was January 2001. The last new hardcopy of the ParaRegs was distributed in December 2000 to all ALJs and to two counties (Kern and San Mateo) and two authorized representative groups (Legal Services of Northern California [the Sacramento office] and Western Center on Law and Poverty [the Los Angeles office]). Interested parties may request a hardcopy from the appropriate contact.

The Plan is that there will be updates every two months, except during my vacation in the summer. The next projected updates are in April, June, and October 2001.

Beginning with the February 2001 issue, the hardcopy will be updated in the manner of a manual, i.e., as Barclay's does in Title 22. Instructions for manual filing follow:

Replace: With: Replace: With: