
Reference: Medi-Cal Eligibility Procedures Manual §5H; ACWDL 99-06

CEC provides for up to 12 months of continued \$0 share of cost (SOC) Medi-Cal for children under age 19, who would otherwise have their SOC increased above \$0 SOC. The CEC period ends with the earlier of the next annual eligibility determination or the child's 19th birthday. Counties must implement CEC by January 1, 2001.

The 12-month CEC period begins with the first month of \$0 SOC eligibility (except for state-only minor consent services). In cases where a child is found eligible for \$0 SOC at application, the 12-month CEC period begins with the initial month of eligibility, not with retroactive months. During this CEC period, any changes in the family's financial eligibility, which would cause the child to have a SOC or be totally ineligible, would not go into effect for the child until the annual redetermination unless the child turned 19 before the annual redetermination.

The CEC period also applies to children to preclude discontinuance for non-financial reasons except for death or loss of California residency. Thus if the family is discontinued from Medi-Cal for failing to provide essential information, the family could be discontinued from Medi-Cal by a notice of action, but the child would continue to receive Medi-Cal until the date of the next annual redetermination.

*California Department of Social Services - State Hearings Division
Notes from the Training Bureau - April 20, 2001*

Item 01-04-01A

CDHS ACWDLs 00-64 December 8, 2000, 01-02 January 8, 2001 and 01-25 April 11, 2001 (Synopsis): Elimination of the Quarterly Status Report (QSR)

Elimination of the Quarterly Status Report (QSR)

ACWDL 00-64 states that effective January 1, 2001, the DHS has eliminated the mandatory QSR for Medi-Cal recipients pursuant to Assembly Bill 2877, Chapter 93, Statutes of 2000.

The elimination of the QSR is effective beginning with any QSR that would have been due to be returned to the county as of January 2001. Beginning January 1, 2001, counties may not take any adverse action based upon a QSR that was incomplete or not returned.

Medi-Cal beneficiaries are still required to report, within ten days, any information that may effect Medi-Cal eligibility such as changes in income, property, family composition or other health care coverage.

ACWDL 01-02 states that as of January 1, 2001, the QSR for the second year of the Transitional Medi-Cal (TMC) program has been eliminated because the second year of TMC is a state program.

ACWDL 01-25 explains that the QSR is still required for the first year of TMC. The first year of TMC is a federal program and federal law requires a status report for TMC persons. This ACWDL also provides other questions and answers regarding the elimination of the QSR.

*California Department of Social Services - State Hearings Division
Notes from the Training Bureau - March 23, 2001*

Item 01-3-1A

Differences Between the In-Home Supportive Services Residual Program and the Personal Care Services Program

Prior to April 1, 1993, aged, blind and disabled persons who would be unable to remain safely in their homes without assistance could apply for In Home Supportive Services (IHSS). IHSS is an alternative to out-of-home care. The IHSS program is authorized under Welfare and Institutions Code (W&IC) Section 12300 et seq. It is 65% state funded and 35% county funded.

Effective April 1, 1993, the Personal Care Services Program (PCSP) was implemented under the Medi-Cal program to cover essentially the same services authorized under IHSS. PCSP is authorized under W&IC Section 14132.95. As a Medi-Cal program, it is 50% federally funded. In some situations, the IHSS program assesses an IHSS share of cost. Recipients of IHSS receive no-cost Medi-Cal as if they were on public assistance, i.e., they have no Medi-Cal share of cost for their "regular" Medi-Cal services.

As viewed by the CDSS and CDHS, there is one program called IHSS which is divided into IHSS residual and PCSP. IHSS residual covers the needs of any persons that are not covered under PCSP.

While both IHSS residual and PCSP come under the broad heading of IHSS, it is important to properly identify whether the issue at hearing involves IHSS or PCSP. IHSS is a social services program and PCSP is a Medi-Cal program. Persons eligible for personal care or ancillary services under PCSP are not eligible for those services under IHSS. (See MPP §30-757.1; W&IC §12300(f))

Prior to April 1, 1999, a case was a PCSP (rather than an IHSS residual) case if the individual:

- Was a recipient of a categorical aid payment, (Title 22 CCR §51350(b));
- Had a disability expected to last 12 months or end in death (Title 22 CCR §51350(b));
- Had a need for at least one personal care service or paramedical service (Title 22 CCR §§51350(a) and 51183);
- Had a service provider who is not the parent (if a minor) or a spouse (Title 22 CCR §51181);