

**Item 01-09-01A**

**ACWDL 01-30 - - May 4, 2001 (Synopsis): Change to the §1931(b) 100-Hour Deprivation Earned Income Test**

**Change to the §1931(b) 100-Hour Deprivation Earned Income Test**

Effective March 1, 2000, an earned income test was added for §1931(b) applicants and for applicants and recipients of the AFDC-MN program when the principal wage earner (PWE) was working 100 hours or more monthly. Effective March 1, 2000, the county was to add up the nonexempt earned income of the PWE, the spouse or second parent and children. If the combined nonexempt income of this family was at or below the applicable 100% Federal Poverty Level (FPL), the children were considered to be deprived due to employment even if the PWE worked in excess of 100 hours monthly.

The DHS requested a state plan amendment to exclude all earned income of children for purposes of determining if the family income met the 100% FPL test. Counties were instructed to flag all cases in which an applicant family for §1931(b) or an applicant or recipient family for AFDC-MN was denied after May 1, 2001 due to excess earned income which included earned income of the child.

Since ACWDL 01-30 was issued, the state plan amendment has been approved and effective May 1, 2001, all earned income of children is excluded for purposes of the 100-hour rule as described in this ACWDL. This ACWDL also included as an attachment an Unemployed Parent Determination Worksheet (MC 337). That form will be revised and separated into two separate forms; one for §1931(b) applicants and a second form for AFDC-MN applicants and recipients.

**Item 01-07-02A**

**Two-Plan Model Managed Care Issues**

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As the number of hearings involving managed care increases, there are additional issues that need to be clarified. This *Notes* discusses some managed care issues that apply to two-plan model counties.

**Aid Issued Pending Decision**

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The Managed Care Division (MCD) has determined that if a claimant has been enrolled in a managed care plan and the fee-for-service provider for the claimant submits a medical exemption request form (HCO 7101) to the HCO program within 90 days after being enrolled in a plan, the person will be disenrolled from the managed care plan pending the hearing decision. **This is not aid pending because the MCD has determined it will disenroll all persons who request a medical exemption within 90 days of enrollment in the managed care plan and who subsequently request a timely state hearing (MCD defines a timely hearing request as one made within 90 days of the notice of action denying the medical exemption), not just those who requested a state hearing prior to the date the claimant is enrolled in the plan.**

In cases where the claimant has requested a state hearing, the issue usually is whether the claimant is entitled to a medical exemption. After the claimant's provider has submitted the HCO 7101 form, the HCO program will evaluate the exemption request. If the HCO program denies the exemption request, it must issue the claimant a Notice of Action (NOA).

The following examples illustrate if and when MCD will disenroll the Medi-Cal beneficiary from managed care pending the hearing decision:

#### Example 1

Jim receives a notice dated June 2, 2001 advising him that he will be enrolled in XYZ Health Plan on July 1, 2001.

Jim is enrolled in XYZ Health Plan on July 1, 2001. Jim goes to see Dr. MRI, his former fee-for-service family doctor. Dr. MRI submits an HCO 7101 form to the HCO program on December 10, 2001. Jim will not be disenrolled, but will remain in XYZ Health Plan because he has been in that plan for more than 90 days.

If the HCO program issues Jim a NOA on December 17, 2001 denying the medical exemption request, he is not entitled to aid paid pending because he was never disenrolled from XYZ Plan. This is so regardless of whether Jim requests a hearing before or after January 1, 2002.

#### Example 2

Jim is enrolled in XYZ Health Plan on December 1, 2000. Dr. MRI submits an HCO 7101 form to the HCO program on February 10, 2001. The HCO program issues Jim a NOA denying his exemption request on February 17, 2001. Jim requests a hearing on March 8, 2001. Per MCD practice, Jim will be disenrolled from XYZ Health Plan because he was enrolled in that plan for less than 91 days before the medical exemption request was submitted. Further, Jim will continue to get fee-for-service Medi-Cal until the hearing decision is issued since he timely requested a fair hearing.

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**Note:** If the HCO program has not disenrolled the claimant from managed care even though he/she submits a medical exemption request before he/she is enrolled or within 90 days after being enrolled, the judge should order MCD to disenroll the claimant from managed care pending the hearing decision. This "aid issued pending decision" order should be addressed to Carmen Romo.

### **90 Day Rule**

Per Title 22 California Code of Regulations (CCR) §53887(a)(2)(B), effective December 19, 2000, a person who is enrolled in managed care (whether in one plan or both plans on a combined basis) for more than 90 days may not be granted a medical exemption from managed care. This rule does not apply retroactively to persons who were enrolled in a plan prior to December 19, 2000. The 90-day period begins December 19, 2000 for those persons who were enrolled in a managed care plan before that date.

This means that the 90-day rule does not apply to any medical exemption request that was submitted on or before March 20, 2001; i.e., 91 days after December 19.

#### Example 1

Mary is enrolled in ABC Health Care Plan on November 1, 2000. She is unhappy with her plan and goes to see Dr. X, her former fee-for-service doctor. Dr. X submits an HCO 7101 form on behalf of Mary on March 15, 2001. Although Mary has been in ABC Health Plan for more than 90 days (i.e., between November 1, 2000 and March 15, 2001) before the HCO 7101 was submitted, the HCO program must evaluate Mary's medical exemption request on the merits rather than deny the exemption request based on the 90 day rule. This is so because the 90-day rule became effective on December 19, 2000. When the HCO 7101 was submitted by Dr. X, Mary had been in ABC plan for only 86 days (i.e., from December 19 through March 15) after the 90-day rule went into effect.

**Note:** Although the HCO program would be required to evaluate the exemption request on the merits rather than based on the 90 day rule, the claimant would not be disenrolled from managed care prior to the hearing because she had been enrolled in ABC plan for more than 90 days before Dr. X. submitted the HCO 7101.

#### Example 2

Same facts as above, except Dr. X does not submit the HCO 7101 form until March 24, 2001. Since Mary was in the plan for more than 90 days after December 19 when the 90 day rule became effective, the HCO program would properly deny the exemption request based on the 90 day rule and without reviewing the merits of the exemption request.

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As a practical matter, for all medical exemption requests submitted after March 20, 2001, (91 days after 90-day rule went into effect) the following applies:

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If the claimant submits the HCO 7101 in 90 days or less after being enrolled in managed care and the claimant files a timely request for hearing to dispute the denial of the medical exemption request, the MCD will disenroll a claimant from managed care. The HCO program will then evaluate the exemption request on its merits.

For any case in which the HCO 7101 is initially submitted more than 90 days after being enrolled in managed care, the MCD will not disenroll the claimant from managed care, nor will the HCO program evaluate the medical exemption request. Rather, the HCO program will deny the request based on the 90-day rule.

### *HCO 7101 Forms Returned As Incomplete*

Charley is enrolled in MNO Health Care Plan effective April 1, 2001. Dr. Y submits a medical exemption form on behalf of Charley on June 14, 2001 (i.e., less than 91 days after Charley was enrolled in MNO plan). The HCO program returns the HCO 7101 form to Dr. Y on June 25 because he failed to answer two questions on the form. Dr. Y then resubmits the HCO 7101 to the HCO program on July 6, 2001 and answers the two questions.

Per MCD, if Dr. Y has made a good faith effort to comply with the medical exemption process, the HCO program is required to evaluate the medical exemption request on the merits rather than deny the request based on the 90-day rule. If the initial request is filed in less than 91 days after Charley was enrolled in MNO, the burden is on the MCD to document that Dr. Y failed to act in good faith in not returning the HCO 7101 in a complete fashion in less than 91 days. If Dr. Y. has not acted in good faith, the MCD will deny the medical exemption request based on the 90-day rule.

### **Orders**

The MCD has indicated that it has had difficulty in complying with certain orders in cases where the ALJ grants the claim and orders the MCD to retroactively reinstate the claimant to fee-for-service Medi-Cal. The reason MCD has had trouble complying is because the claimant has received services from the managed care plan in the month at issue. Thus if the claimant received services from DEF plan in March 2001, the claimant is not also supposed to receive fee-for-service Medi-Cal in that month.

MCD has requested that to the extent possible, granted decisions should instruct MCD to disenroll the claimant prospectively. Judges are advised to determine if a claimant has been a patient of a fee-for-service doctor in a retroactive month before ordering a retroactive remedy. If the claimant has been a patient of a fee-for-service doctor in any retroactive month and the judge orders a retroactive remedy, the judge should identify the month(s) the claimant was a patient of a fee-for-service doctor in the conclusion of the decision.

**Note:** All decisions should come to DHS as **Proposed** decisions not **adopted final** decisions.