
eligibility requirements, but meet State-only BCCTP standards, will receive services limited to cancer treatment for a specified time period (i.e., 18 months for breast cancer and 24 months for cervical cancer).

The toll-free number for persons wanting information on the Breast and Cervical Cancer Treatment program is 1-800-824-0088.

The CDHS should be issuing an ACWDL before the end of June that gives more details on the BCCTP.

*California Department of Social Services - State Hearings Division
Notes from the Training Bureau - May 2, 2002*

Item 02-05-01E

Does Senate Bill 87 Apply to Medi-Cal Recipients Not Administered by the County

CalWORKs except when such person is clearly ineligible for § 1931(b) Medi-Cal. In addition, per Welfare and Institutions Code (W&IC) § 14005.37(a), counties are required to continue Medi-Cal benefits and evaluate Medi-Cal eligibility for all Medi-Cal recipients after they receive information that may effect eligibility for Medi-Cal. These provisions had to be implemented by July 1, 2001.

The applicable statutory authority for the redetermination process is found at Welfare and Institutions Code (W&IC) §§14005.30 through .39, particularly .37. The CDHS issued All County Welfare Director's Letter 01-36 dated June 19, 2001 that discussed changes in the Medi-Cal redetermination process. The changes to the redetermination process included an ex parte process in which the county makes a Medi-Cal only eligibility determination without the involvement of the person whose Medi-Cal is discontinued.

The ex parte process is used in a variety of circumstances such as when CalWORKs is discontinued because the caretaker relative failed to complete the annual redetermination process, when the only child in a CalWORKs family leaves the home, or there is a loss of contact with the family. In these and other circumstances, the county is required to evaluate Medi-Cal eligibility without contacting the claimant by checking resources such as the Income Eligibility and Verification System (IEVS), the Employment Development Department or the Systematic Alien Verification for Entitlements (SAVE) system.

When the ex parte process is unsuccessful in determining whether the person is eligible or ineligible for Medi-Cal, the county is permitted to contact the claimant by telephone to request necessary information. The county must document in the case record the exact reason for calling the individual.

If the ex parte and telephone contacts are unsuccessful, the county is required to send an MC355 form to the person to request the necessary information.

As stated above, while ACWDL 01-36 mostly refers to persons discontinued from CalWORKs, this entire process for redetermining eligibility applies to all Medi-Cal beneficiaries. Thus assume a Medi-Cal beneficiary was receiving Medi-Cal for herself and her 20 year-old son based AFDC linkage. The county issues a notice of action discontinuing Medi-Cal effective April 30, 2002 because the son turned 21. The county must continue to issue Medi-Cal while it redetermines eligibility.

If the beneficiary alleges she is disabled and no other basis for Medi-Cal eligibility exists, the county must continue to issue Medi-Cal to the beneficiary and refer the case to the Disability and Adult Programs Division (DAPD). The county must continue to issue Medi-Cal to the beneficiary pending the DAPD disability determination.

While it is clear that the redetermination process applies to all Medi-Cal beneficiaries administered by the county, there is a dispute as to whether it applies to persons not administered by the county. The question is thus whether the CDHS or county is obligated to apply this redetermination process to a person who is discontinued from SSI/SSP linked Medi-Cal benefits.

Craig v. Bonta was filed on March 19, 2002 in the San Francisco Superior Court. The plaintiffs in Craig contend that the CDHS is responsible to redetermine Medi-Cal eligibility for all persons who were discontinued from SSI/SSP linked Medi-Cal. The petitioners contend that the CDHS must go through the SB 87 redetermination process without the involvement of the Medi-Cal beneficiary whose Medi-Cal has been discontinued even if he/she did not return a Medi-Cal application to the county.

Petitioners rely on W&IC §§14005.37(a) and (d). Those sections state:

"(a) Except as provided in Section 14005.39, whenever a county receives information about changes in a beneficiary's circumstances that may affect eligibility for Medi-Cal benefits, the county shall promptly redetermine eligibility. The procedures for redetermining Medi-Cal eligibility described in this section shall apply to all Medi-Cal beneficiaries."

"(d) Except as otherwise provided in this section, Medi-Cal eligibility shall continue during the redetermination process described in this section. A Medi-Cal beneficiary's eligibility shall not be terminated under this section until the county makes a specific determination based on facts clearly demonstrating that the beneficiary is no longer eligible for Medi-Cal under any basis and due process rights guaranteed under this division have been met."

Based upon these two sections, petitioners contend: "The legislatively mandated redetermination process is a comprehensive one that specifically places the burden on (DHS) and their counties for ensuring that 'all' eligible beneficiaries retain their Medi-Cal benefits and are not inaccurately or prematurely cut-off from critical health care services.... Only where a complete redetermination 'makes a specific determination based

on facts clearly demonstrating that the beneficiary is no longer eligible for Medi-Cal under any basis' may the beneficiary's Medi-Cal eligibility be terminated".

The DHS has not advised the State Hearings Division of any position it has taken on this case. Judges are reminded that they should write any case involving an SB 87 issue in Ramos cases as proposed decisions. Judges should also write proposed decisions on any other case involving SB 87 that is not in conformity with DHS policy.

Proposed decisions regarding SB 87 should be directed to:

Marlene Ratner,
Department of Health Services
Medi-Cal Eligibility Branch
714 P. St. Rm 1692
Sacramento, California 95814

*California Department of Social Services - State Hearings Division
Notes from the Training Bureau - May 2, 2002*

Item 02-05-01D

Payment of the Medicare Part B Premium to Establish Eligibility for the Aged and Disabled Federal Poverty Level Program

All County Welfare Director's Letter (ACWDL) 01-18 dated March 16, 2001 provided questions and answers regarding the Aged and Disabled Federal Poverty Level (A&D FPL) program. In the answer to question 8 of that ACWDL, it was stated that a person could pay a health care premium to qualify for the A&D FPL program.

The CDHS has determined that this answer only applies to health insurance premiums, and not to the Medicare Part B premium. That is, after the first two months on Medi-Cal, per Title 22 CCR § 50773, the CDHS makes the payment of the Medicare Part B buy-in on behalf of the Medi-Cal beneficiary. This payment is made per an agreement between the CDHS and the Social Security Administration.

Under the current agreement between the CDHS and the Social Security Administration, the CDHS may not permit a Medi-Cal recipient to opt out of the Medicare Part B buy-in on an individual basis.

*California Department of Social Services - State Hearings Division
Notes from the Training Bureau - May 2, 2002*

Item 02-05-01C

The \$20 Any Income Deduction

Title 22 CCR §50549.2 says: