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## MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION

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### 15A—IDENTIFYING, REPORTING AND CODING OTHER HEALTH COVERAGE (OHC)

This section provides information and procedures regarding identifying, reporting and coding of Other Health Coverage (OHC). Eligibility workers code OHC on the Medi-Cal Eligibility Data System (MEDS) and issue the Health Insurance Questionnaire (DHS 6155, revision date 2/90 or later) during each application and redetermination interview when applicant or beneficiary responds with a positive answer to the Other Health Coverage Question on the Aid to Families with Dependent Children (AFDC) Statement of Facts Supporting Eligibility for Assistance form (SAWS 2) or Statement of Facts form (MC 210). Form DHS 6155 is used by county Welfare Offices to report Other Health Coverage to the Department of Health Services (DHS) for inclusion on the Health Insurance System (HIS).

#### 1. Background and Overview

The Department of Health Services is responsible for ensuring that Medi-Cal is the payor of last resort for medical care used by Medi-Cal eligibles in accordance with State Statute Welfare and Institutions Code Section 14124.90 and Federal Law (Section 1902(a) (25) of the Social Security Act). State laws (Welfare and Institutions Code, Sections 10020, 14000, 14003, 14005, 14016.3, and 14024) require Medi-Cal beneficiaries to report and utilize these resources before using Medi-Cal. In instances where Medi-Cal has paid for a beneficiary's medical care first, these laws also require the program to seek reimbursement from the responsible third party.

Since the Medi-Cal program is prohibited by federal law from paying for services which are covered by the beneficiary's health insurance or health plan, in most instances, providers must bill the appropriate carrier before billing Medi-Cal. This is called cost avoidance. If a beneficiary is enrolled in a private Prepaid Health Plan/Health Maintenance Organization (PHP/HMO), the beneficiary must be directed to his or her respective plan for treatment. Medi-Cal is not obligated to pay for services available through a PHP/HMO plan when the beneficiary chooses to seek treatment elsewhere.

In limited instances, a provider may bill the Medi-Cal program directly even though a beneficiary has OHC. The Department of Health Services then recovers the Medi-Cal payment from health insurance carriers using the State's automated billing system.

#### 2. Definition of Other Health Coverage

Other Health Coverage (OHC) is defined as benefits for health related services or entitlements for which a Medi-Cal beneficiary is eligible under any private, group, or indemnification insurance program, under any other State or federal medical care program, or under other contractual or legal entitlement.

#### 3. Types of Other Health Coverage That Must Be Reported

Insurance policies on the following list provide Other Health Coverage benefits. A Health Insurance Questionnaire (DHS 6155, revision date 2/90 or later) must be completed to identify the health coverage source and scope of coverage for these insurance types.

- a. Cancer Only – Policies that cover medical expenses related to cancer treatment only.

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- b. **CHAMPUS** – The Civilian Health and Medical Program of the Uniformed Services pays for care delivered by health providers to retired members and dependents of active and retired members of the Armed Forces under 65.
- c. **Dental Only** – Policies that cover expenses related to dental work.
- d. **Employment-related Health Insurance** – Health insurance provided to employees and their dependents. This could include health insurance through union membership or membership in a national organization, fraternity or trust fund.
- e. **Employee Retirement Income Security Act (ERISA) Trusts** – Any health insurance that is offered through a trust fund operated by an employer under the authority of the U.S. Department of Labor (e.g., Carpenters, Pipefitters, Plumbers, Laborers, etc.).
- f. **Group Health** – Policies that provide health benefits to persons employed by or affiliated with an entity such as an employer, union, association or organization.
- g. **Health** – Policies that cover hospital expenses, surgical expenses, routine medical expenses, or major medical.
- h. **Hospital** – Policies that cover expenses incurred during hospitalization.
- i. **Indemnity** – Policies that pay benefits in the form of cash payments. These benefits are paid to the insured instead of the provider or services.
- j. **Long Term Care** – Policies that cover long term care expenses (e.g., custodial care, intermediate care, skilled nursing care).
- k. **Major Medical** – Policies that cover medical expenses over and above those expenses covered by a basic benefit plan.
- l. **Medical Support From Absent Parents** – An absent parent may be required to provide medical insurance premium payments or be responsible for a portion of medical bills, or, if employed, may be required to include dependent children in the medical insurance plan provided by the employer.
- m. **Medicare Supplemental** – Policies which pay that portion of medical services which Medicare does not pay.
- n. **Prepaid Health Plan/Health Maintenance Organization (PHP/HMO)** – Any health benefit plan which provides a wide range of comprehensive health care services for persons insured by the policy or plan. Services are provided by plan designated providers at designated facilities.
- o. **Prescription** – Policies that cover prescribed drugs only.
- p. **Student Health** – Health insurance offered through an educational institution for enrolled students.
- q. **Surgical** – Policies that cover surgery-related expenses only.

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r. Vision – Policies that cover vision-related expenses only.

4. Types of Coverage/Benefits and Situations When Other Health Coverage Should Not Be Reported

The Department is specifically excluding the following coverage from the Other Health Coverage (OHC) coding requirements and/or reporting on a revision date 2/90 or later.

- a. Accident Benefits.
- b. Automobile, Burial, and Life Insurance benefits.
- c. Casualty Workers Compensation benefits.
- d. Disability benefits.
- e. Medicare (Title XVIII benefits).
- f. Veteran's Administration (VA) benefits.
- g. Coverage under a PHP/HMO which has contracted with the Department to provide Medi-Cal services to enrolled beneficiaries. (Medi-Cal Capitated Health Plans)
- h. Coverage which is considered unavailable in the following situations:
  - (1) Coverage under any plan which is limited to a specific geographic service area and the beneficiary lives outside that area or the plan requires use of specified providers(s) and the beneficiary lives more than 60 miles or 60 minutes travel time from the specified provider(s). The beneficiary should be advised that many of these plans cover out of area care in emergency situations. In this situation, the beneficiary should provide OHC information to the emergency medical provider so that the provider may bill the plan before billing Medi-Cal.
  - (2) Coverage to which a child may be entitled when:
    - (a) The parent or guardian refuses to provide the necessary information due to "good cause". Good cause shall be determined by the county. Good cause exists when cooperation in securing medical support and payments, establishing paternity, and obtaining or providing information concerning liable or potentially liable third parties from the absent parent can be reasonably anticipated to result in serious physical or emotional harm to the child for whom support is to be sought or to the parent or caretaker with whom the child is living, or;

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- (b) The absent parent cannot be located; and
  - (c) The child is applying for Medi-Cal independently and would be in a separate Medi-Cal Family Budget Unit (MFBU) from the custodial parent or guardian.
  - (d) the child is applying for Medi-Cal independently and has no custodial parent or guardian. Adult children under Section 50014.
- (3) Any coverage to which a child may be entitled in those instances where the child is applying for minor consent services in accordance with California Administrative Code, Title 22, Section 50147.1. The obligation to report and utilize OHC before using Medi-Cal coverage is not enforced in this situation, since utilization of OHC would violate the minor's right to confidentiality regarding his/her medical services.

### 5. County Responsibilities for Identifying Other Health Coverage (OHC)

#### a. Review Statement of Facts:

Review the applicant's/beneficiary's MC 210 or CA 2 to determine if there is a positive response to the question about having private health insurance or hospitalization insurance. If there is a positive response, go to procedure 6 (Reporting Other Health Coverage Information). If there is no positive response to having private health insurance on the MC 210 or CA 2, but the applicant/beneficiary is or was recently employed; has health insurance available through an employer or family member's employer, but has not enrolled; retired; serves or served in the military; or there is an absent parent, proceed to procedure (b). If there is no positive response after determining non-availability of insurance, there is no need to complete the DHS 6155.

Section 4402, Omnibus Budget Reconciliation Act of 1990 (OBRA '90) mandates that when it is cost effective, enrollment in an employer or group health plan is a condition of Medicaid eligibility. Additionally, Section 50763(a)(1) California Code of Regulations requires that a Medi-Cal beneficiary shall apply for, and/or retain any available health insurance when no cost is involved.

#### b. Ask Questions to Identify OHC:

The following are key questions to ask applicants/beneficiaries for identifying the availability of OHC:

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TO EXPLORE WORK RELATED QUESTIONS	YES	NO
Does your employer (or a family member's employer) provide a health insurance plan?	If applicant/beneficiary currently HAS health insurance through an employer (or family member's employer), complete the DHS 6155 with the current insurance information. If insurance is available, but applicant/beneficiary has not enrolled, complete the DHS 6155 as an Employer Group Health Plan (EGHP) referral (refer to Section 15H for further information regarding EGHP).	Do not complete the DHS 6155.
Did your former employer (or a family member's employer) provide health insurance coverage within the last three (3) years?	Complete the DHS 6155 and provide the insurance beginning and ending dates.	Do not complete the DHS 6155.
Are you covered by your union's health insurance plan?	Complete the DHS 6155 with the health insurance information.	Do not complete the DHS 6155.
Were you covered by your union's health insurance plan within the last three (3) years?	Complete the DHS 6155 and provide the insurance beginning and ending dates.	Do not complete the DHS 6155.
Does an absent parent (or the absent parent's employer) provide health insurance coverage for you and/or your children?	Complete the DHS 6155.	Complete the CA2.1 Medical Support Referral packet. Do not complete the DHS 6155.
Did an absent parent (or the absent parent's employer) provide health insurance coverage for you and/or your children within the last three (3) years?	Complete the DHS 6155 and provide the insurance beginning and ending dates. Complete the CA2.1 Medical Support Referral packet also.	Complete the CA2.1 Medical Support Referral packet. Do not complete the DHS 6155.

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Do you belong to any national organization (e.g., Foresters, Eagles, etc.)? Do you have health insurance through the organization?	Complete the DHS 6155 with the health insurance information.	Do not complete the DHS 6155.
Were you ever covered by insurance through any national organization (e.g. Foresters, Eagles, etc.) within the last (3) years?	Complete the DHS 6155 and provide the insurance beginning and ending dates.	Do not complete the DHS 6155.
<b>IF THE APPLICANT/BENEFICIARY IS OVER AGE 65, RETIRED, OR DISABLED:</b>	<b>YES</b>	<b>NO</b>
Do you have Medicare coverage?	If applicant/beneficiary <b>ONLY</b> has Medicare coverage and <b>NO</b> additional supplementary insurance plan, do not complete the DHS 6155.	
Do you have health insurance in addition to Medicare (such as a Medigap or Medicare supplement policy)?	Complete the DHS 6155 with the health insurance information.  Inform person they do not need OHC.	Do not complete the DHS 6155.
Did you have health insurance in addition to Medicare within the last three (3) years?	Complete the DHS 6155 and provide the insurance beginning and ending dates.  Inform person they do not need OHC.	Do not complete the DHS 6155.
Do you have health insurance through a pension or retirement plan?	Complete the DHS 6155 with the health insurance information.	Do not complete the DHS 6155.
Did you have health insurance through a pension or retirement plan within the last three (3) years?	Complete the DHS 6155 and provide the insurance beginning and ending dates.	Do not complete the DHS 6155.



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TO EXPLORE OTHER INSURANCE POSSIBILITIES:	YES	NO
Are you (or spouse or absent parent) enrolled in any educational program? If so, is health insurance available through a student health plan?	Complete the DHS 6155 with the health insurance information.	Do not complete the DHS 6155.
Were you (or your spouse or absent parent) enrolled in any educational program that offered health insurance within the last three (3) years?	Complete the DHS 6155 and provide the insurance beginning and ending dates.	Do not complete the DHS 6155.
Are you (or your spouse or absent parent) in the military? <b>DO NOT ASSUME THAT ONLY MEN HAVE SERVED IN THE MILITARY!</b> If so, ask if military insurance is available to applicant/beneficiary and/or his/her dependent(s). *	If the applicant/beneficiary currently has insurance available through CHAMPUS, complete the DHS 6155 with the health insurance information. If insurance is available, but applicant/beneficiary has not enrolled, they should be instructed to contact the California Defense Enrollment Eligibility Reporting System (DEERS) Center at 1-800-334-4162 to find out how to go about enrolling for CHAMPUS benefits.	Do not complete the DHS 6155.
Were you (or your spouse or absent parent) in the military within the last three (3) years?*	Complete the DHS 6155 and provide the insurance beginning and ending dates.	Do not complete the DHS 6155.
<p><b>*NOTE:</b> Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is a health benefits program for all seven uniformed services: the Army, Navy, Marine Corps, Air Force, Coast Guard Public Health Services, and National Oceanic and Atmospheric Administration. Covered persons include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• husbands, wives, and unmarried children of active-duty service members;</li> <li>• retirees, their husbands or wives, and unmarried children; and</li> <li>• unremarried husbands and wives and unmarried children of active duty or retired service members who have died.</li> </ul>		

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<b>TO EXPLORE OTHER INSURANCE POSSIBILITIES:</b>	<b>YES</b>	<b>NO</b>
How have you paid for your medical care, prescriptions, and eyeglasses before now?	If the applicant/beneficiary indicates that these services have or are covered by insurance, complete the DHS 6155 with the health insurance information. Provide the ending insurance date if applicable.	

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c. Inform Applicant/Beneficiary:

(1) Reporting OHC Does Not Affect Medi-Cal Eligibility:

Inform applicants/beneficiaries that having and reporting OHC does not in any way interfere with their eligibility for or use of Medi-Cal benefits. Under federal law Medi-Cal providers cannot deny care because a beneficiary has OHC.

(2) Do Not Advise Applicants/Beneficiaries To Drop OHC: except if they are on Medicare. Federal law requires us to inform them they do not need Medigap insurance.

(3) Responsibility To Report And Apply For/Retain Employer Related Health Coverage Benefits:

Advise applicants/beneficiaries that federal law requires an individual, as a condition of Medi-Cal eligibility (in order to become or remain Medi-Cal eligible), to report employer related health insurance benefits available to him/her. The Medi-Cal program may pay the health coverage premiums if it is determined cost-effective. Forward any information obtained from applicants/beneficiaries with available employer related health benefits to the Department's Health Insurance Premium Payment program for review of cost-effectiveness (refer to Procedure Manual, Article 15, Section 15H - Health Insurance Premium Payment Program).

(4) Responsibility To Report and Repay Medi-Cal For Insurance Payments Received:

(a) Forward reimbursement payments to:

Department of Health Services  
Third Party Liability Branch  
P.O. Box 671  
Sacramento, CA 95812-0671

(b) Beneficiaries should endorse checks from insurance carriers as follows:

- Name of Payee – Party to whom the check is made payable. Signed either by the payee or their agent.
- Medi-Cal Identification Number of Beneficiary – This may be a different person than the one who received the check.
- "For Deposit Only to Health Care Deposit Fund" – This will ensure that the check will be properly applied to the State fund only.

(c) Beneficiaries must enclose with the check the date(s) of service, the provider's name, and a daytime phone number where they can be reached.

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(5) **Confidentiality for Minor Consent Services:**

Inform applicants/beneficiaries for minor consent services that Medi-Cal will not report coverage nor bill private insurance carriers for such services provided to beneficiaries under 21 years of age who are receiving minor consent services. When a restricted Minor Consent service card is issued to a minor, the card should not be coded with an OHC code and OHC should not be reported on MEDS nor on a Health Insurance Questionnaire (DHS 6155, revision date 2/90 or later).

6. Reporting Other Health Coverage Information - County And Applicant/Beneficiary Responsibilities

County Responsibilities

a. **Issuance of Health Insurance Questionnaire (DHS 6155):**

If the applicant/beneficiary indicates, either on the statement of facts or verbally, that he/she has OHC or OHC is available through an employer, issue the Health Insurance Questionnaire (DHS 6155, revision date 2/90 or later). The applicant/beneficiary completes the DHS 6155 for the types of coverage outlined in Section 15A 3. (Types of Other Health Coverage That Must be Reported) for all members of the family budget unit with OHC. Help the applicant/beneficiary complete the form by asking if he/she has an insurance identification card or other materials that may contain the necessary information.

b. **Completion And Accuracy of The DHS 6155:**

Review the DHS 6155 for complete and accurate information.

- Check the accuracy of information, particularly numbers. Be sure to check the Social Security numbers, birth dates, policy/group numbers and phone numbers. If possible, attach a copy of the policy or copy of the insurance card.
- Be sure the applicant's/beneficiary's name is listed, if covered, and is spelled correctly.
- Be sure the applicant's/beneficiary's complete address is provided.
- Be sure the insurance policy holder's name is provided and spelled correctly. This name may be different from the applicant's/beneficiary's name.
- Be sure the insurance policy holder's Social Security number is provided.
- Provide complete and accurate eligibility worker information. This includes worker number and telephone number, including area code.
- Be sure the form is signed by the applicant/beneficiary and dated.

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c. **Information On Scope of Coverage:**

When reviewing a completed DHS 6155, check the scope of coverage field, item 10, to insure this information is reported. If the applicant/beneficiary does not know the scope of coverage, request that he/she either review the policy or contact the insurance carrier to obtain this information. Scope of coverage information is essential in completing the DHS 6155 and must be provided. See Section 15A (8. Scope of Coverage) for more information about scope of coverage.

d. **Applicants/Beneficiaries With More Than One Insurance Policy:**

If the applicant/beneficiary has more than one insurance policy, provide him/her with a DHS 6155 to be completed for each carrier. This includes policies covering single services, such as dental only coverage and vision services.

e. **Code MEDS with the Appropriate OHC Code:**

Please refer to Section 15A (7. Coding Other Health Coverage Information on The Medi-Cal Eligibility Data System) for procedures.

f. **Batching and Mailing DHS 6155:**

Weekly, batch and mail the white copy of the DHS 6155 and any copies of health insurance identification cards or health insurance policies to:

Department of Health Services  
Health Insurance Section  
P.O. Box 1287  
Sacramento, CA 95812-1287

g. **Retain the Yellow Copy of the DHS 6155:**

Retain a copy of the DHS 6155 form in applicant's/beneficiary's case file.

h. **Send the Pink Copy to DA or Beneficiary:**

Send the pink copy of the DHS 6155 to the DA's office in absent parent cases. Give it to the beneficiary when it is not an absent parent situation (refer to Procedure Manual, Article 23, Medical Support Program).

i. **Notify the Department of OHC Changes, Lapses in Coverage, or Changes in Scope of Coverage:**

When there has been a change to the scope of coverage, policy number, insurance billing information, or if the beneficiary's OHC has lapsed, will lapse or change, update MEDS with the corrected OHC code as needed. County Eligibility Workers (EWs) must send in corrected OHC information on a completed DHS 6155 or by calling the Department of Health Services Health Insurance Section at 1-800-952-5294 when:

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- (1) OHC has changed or is obtained;
- (2) If reporting was not timely, but the county learns OHC has terminated or changed within 12 months prior to redetermination, ask beneficiary to complete a DHS 6155. Include the policy's termination date.

Inform beneficiaries that such information must be reported to the county within ten (10) days following the event.

j. **Verification of Terminated Other Health Coverage**

When a beneficiary indicates that his/her OHC has terminated counties must obtain verification of OHC termination prior to removing the OHC code from Medi-Cal Eligibility Data System. Verification of OHC termination will be either.

- (1) A payroll or pension check stub which shows deductions for private health insurance have ceased.
- (2) An Explanation of Benefits from the insurance carrier showing the date the policy terminated.
- (3) A termination letter from the insurance carrier and/or the employer showing the date the policy terminated. If the letter indicates that continuation of medical benefits is available under Consolidated Omnibus Budget Reconciliation Act (COBRA) law, and the beneficiary has a high cost medical condition, complete a Health Insurance Questionnaire (DHS 6155) in time to ensure that the policy can be continued and send it to the Department's Health Insurance Premium Payment Unit, P.O. Box 1287, Sacramento, CA 95812-1287. You may fax the DHS 6155 to (916) 322-8778 or call 1-800-952-5294 for more information.
- (4) Affidavit signed by the applicant/beneficiary stating he/she no longer has, or never had, OHC. This affidavit should also include the date the policy terminated, if known. This affidavit should be used when an erroneous OHC code appears on a recipient's Medi-Cal card after the Department conducts a data match with an insurance company.

k. **High Cost Medical Condition**

Medi-Cal eligibles who have a high cost medical condition should be referred to the Department's Health Insurance Premium Payment (HIPP) Program as specified above. For more information about the HIPP Program, please refer to Section 15H of the Medi-Cal Eligibility Procedures Manual.

l. **Employer Group Health Plan**

Medi-Cal eligibles who have health insurance available through an employer (or a family member's employer) should be referred to the Department's Employer Group Health Plan (EGHP) Program. For more information about the EGHP Program, please refer to Section 15H of Medi-Cal Eligibility Procedures Manual.

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m. **Notify the Department of OHC Termination**

County eligibility workers must maintain a copy of the verification of OHC termination in the case file as well as send a completed DHS 6155, showing the policy stop date, to the Department. For Supplemental Security Income/State Supplemental Payment cases, county eligibility workers should delete the OHC code, attach a copy of the verification of OHC termination of the completed copy of the DHS 6155 showing termination date and send both documents to the Department.

**Applicant/Beneficiary Responsibilities**

(1) **Report Current OHC Information to Counties:**

Applicants/beneficiaries who have contractual or legal entitlement(s) to any health care coverage must disclose this information to the EW and must also provide specific health information to the health care provider so that the provider may bill the liable third party.

(2) **Report Available OHC to Counties:**

Applicants/beneficiaries are required to report the availability of employer related health benefits.

(3) **Report OHC Changes to Counties:**

Applicants/beneficiaries who change, terminate, or obtain OHC must report such information to the county within ten (10) days following the event.

(4) **Report OHC Information to Providers:**

Applicants/beneficiaries are required to provide current OHC billing information to the provider at the time medical/dental services are received. This information shall include group number and billing office address. Willful failure to provide such information may allow a provider to bill the beneficiary as a private pay patient.

7. **Coding Other Health Coverage Information on the Medi-Cal Eligibility Data System**

Eligibility Workers (EWs) must code Other Health Coverage (OHC) on the Medi-Cal Eligibility Data System (MEDS) at the time eligibility is determined or redetermined or at any time a beneficiary reports a change in coverage.

a. **Coding for No OHC:**

When an applicant/beneficiary states that he/she does not have OHC, enter the letter code "N" (No Other Health Coverage) on MEDS in the OHC field.

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b. **Coding OHC:**

The following is a list of OHC codes and instructions on how to determine the appropriate OHC code to place on MEDS. In order to determine the appropriate code, the following questions should be asked at the application and redetermination interview once the applicant/beneficiary has reported OHC:

- Does your health insurance provide or pay for hospital in-patient care?
- Does your health insurance pay for hospital outpatient care (e.g., emergency room visits, lab work, physical therapy)?
- Does your health insurance pay for doctor's visits?
- Does your health insurance pay for prescriptions?

(1) **Cost Avoidance OHC Codes:**

If the applicant/beneficiary answers "yes" to at least three of the four questions listed above, enter the appropriate cost avoidance code on MEDS. Cost avoidance codes to use are:

B	Blue Cross
C	CHAMPUS Prime*
D	Prudential
E	Aetna
F	Medicare HMO Risk
G	General American
H	Mutual of Omaha
I	Metropolitan Life
J	John Hancock
K	Kaiser
L	Dental Only Policies
P	PHP/HMO, not otherwise specified
Q	Equicor
S	Blue Shield
T	Travelers
U	Connecticut General (CIGNA)
V	Variable, any carrier not uniquely identified
W	Great West Life Insurance
2	Provident Life and Accident
3	Principal Financial Group
4	Pacific Mutual Life Insurance
5	Alta Health Strategies, Inc.
6	American Association of Retired Persons (AARP)
8	New York Life Insurance

\* Please note effective August 10, 1994 CHAMPUS Standard or CHAMPUS Extra other health coverage should be coded with the OHC cost "V".



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- (2) Prepaid Health Plan/Health Maintenance Organization/Competitive Medical Plan (PHP/HMO/CMP) Other Health Coverage Codes:

If you determine from the questions above that an applicant/beneficiary record requires a cost avoidance code, ask the beneficiary: "Does your insurance or Medicare plan cover medical services only from specific facilities or providers?" If the applicant/beneficiary answers "yes", enter a PHP/HMO/CMP code on MEDS. If the applicant/beneficiary has Kaiser or CHAMPUS Prime, assign a "K" or "C" code. If the applicant/beneficiary has Medicare HMO/CMP coverage, assign an "F" code. Code any other PHP/HMO with a "P", even though a unique cost avoidance code may exist for the carrier's fee-for-service coverage. For example, should an applicant/beneficiary have full coverage through Travelers Insurance, but coverage is limited to services provided by a specific group of professionals and hospitals, use the PHP/HMO code "P" instead of the cost avoidance code "T".

Medi-Cal beneficiaries covered by Kaiser, CHAMPUS Prime, or other PHP/HMO/CMPs must use designated facilities. Medi-Cal will reject bills for services provided to beneficiaries with cards coded "K", "C", "P", or "F". Medi-Cal will pay for services only when the service is not a covered benefit under the designated plan. The service provider, however, must attach payment denial information from the plan indicating the service is not a covered plan benefit. This will generate an override in the claims payment system and allow payment to the provider.

Since the Department cannot obtain reimbursement from Kaiser, CHAMPUS Prime, or other PHP/HMO/CMPs, the importance of the "K", "C", "P", or "F" coding on the Medi-Cal card cannot be overemphasized.

- (3) Post Payment Recovery OHC Codes:

If the applicant/beneficiary responds "yes" to fewer than three of the four questions listed above, or if the applicant/beneficiary does not know the scope of coverage, enter the following post payment recovery codes:

- A Other Coverage code for any insurance company;
- M Multiple coverage; beneficiary has more than one insurance company (use only when companies are identified as post payment recovery codes).
- X BLUE SHIELD
- Z BLUE CROSS

- (4) Multiple Cost Avoidance or PHP/HMO/CMP Other Health Coverage:

If an applicant/beneficiary has multiple (two or more) full coverage policies, one of which is a PHP/HMO/CMP, use the appropriate PHP/HMO/CMP code (K, C, P, or F). Otherwise, assign the appropriate cost avoidance code for the carrier that provides the most comprehensive coverage.

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(5) Dental OHC Code:

If the applicant/beneficiary responds "no" to all four questions listed above, ask if he/she has an insurance policy for dental only coverage. If the applicant/beneficiary responds "yes" to having dental only coverage and he/she does not have any other health insurance policy, enter the cost avoidance code "L" (Dental Only Policies) on MEDS.

8. Scope of Coverage

Upon receipt of a Health Insurance Questionnaire (DHS 6155, revision date 2/90 or later), the Department enters insurance billing information and scope of coverage codes onto the Health Insurance System (HIS). This information is printed on Medi-Cal cards. The scope of coverage information assists providers in determining which services must be billed to the beneficiary's insurance. The scope of coverage codes are as follows:

I	-	Hospital Inpatient Care
O	-	Hospital Outpatient Care
M	-	Medical/Doctor's Visits
P	-	Prescription Drugs
L	-	Long Term Care
V	-	Vision Care
D	-	Dental Care

When an EW initially assigns a post payment recovery code on the MEDS, the Department will change it to a cost avoidance code upon receiving the DHS 6155 and enter the scope of coverage codes on HIS. Replacement of the post payment recovery code with a cost avoidance code when scope of coverage has been entered is a correct procedure. Counties are not to change the cost avoidance code back to the original post payment recovery code.

If Medi-Cal beneficiaries have health insurance, but the Medi-Cal program has not yet received information about the insurance coverage, the word "COMPREHENSIVE" will appear on Medi-Cal cards instead of scope of coverage codes. This designation "COMPREHENSIVE" alerts providers to bill the other health insurance for all services provided.

When a change to the scope of coverage, policy number, or insurance billing information is necessary, request corrections by either submitting a corrected DHS 6155 or calling the Department's Health Insurance Section at 1-800-952-5294.

9. Current and/or Prior Month Changes to Other Health Coverage Codes

a. Current and/or Prior Month Changes for New Eligibles:

If beneficiaries are initially eligible for Medi-Cal and are reported with a cost avoided insurance policy, counties may enter a cost avoidance code for current and/or prior months.

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## MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

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b. Current and/or Prior Month Changes for Ongoing Cases:

No cost avoidance Other Health Coverage (OHC) codes may be assigned to current and/or prior months for ongoing cases. The message M373 "ONLY PAY AND CHASE (POST PAYMENT RECOVERY) OTHER-COV ALLOWED WHEN ELIGIBLE ON MEDS" will appear when EWs attempt to enter a cost avoidance OHC code to current and/or prior months for a beneficiary who is already MEDS eligible.

If an ongoing eligible has been identified with unreported OHC which is currently available or was available at any time during MEDS' history months, assign the post payment recovery code "A" for the current and prior months and use the appropriate OHC code for the pending month. Send a completed Health Insurance Questionnaire (DHS 6155, revision date 2/90 or later) to the Department. It is very important for EWs to make sure the insurance policy start date is included on the DHS 6155 because the retroactive post payment recovery process enables the Department to bill the insurance carrier for services already received.

The following illustrates the propriety of various OHC code changes for current and/or prior months:

### PERMISSIBLE CHANGES

Cost Avoidance Code	TO	Post Payment Recovery Code
Cost Avoidance OR Post Payment Recovery Code	TO	No Other Health Coverage Code (N)
No Other Health Coverage (N)	TO	Post Payment Recovery Code

### PROHIBITED CHANGES

No Other Health Coverage (N)	TO	Cost Avoidance Code
Post Payment Recovery Code	TO	Cost Avoidance Code
Cost Avoidance Code	TO	A Different Cost Avoidance Code

10. Medi-Cal Eligibility Data System On-Line Other Health Coverage Code Override Process

a. County-Controlled Cases:

To change the Other Health Coverage (OHC) code to cost avoidance for the future month on county-controlled cases, report the proper cost avoidance code by using an EW20 or EW30.

If a corrected Medi-Cal card is required for a current and/or prior months, use an EW15 to change the OHC code to a post payment recovery code "A" and issue the corrected Medi-Cal card(s).

When making on-line changes to OHC codes, always send in a Health Insurance Questionnaire (DHS 6155, revision date 2/90 or later) containing the old insurance policy information to the Department (include termination date of the policy). Submit another DHS 6155 containing the new insurance policy information (include the start date and scope of coverage of the policy).

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## MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

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b. Supplemental Security Income/State Supplemental Payment Cases:

To change the OHC code to cost avoidance for the future month on Supplemental Security Income/State Supplemental Payment (SSI/SSP) cases, report the proper cost avoidance code for the future month by submitting a completed DHS 6155 to the Department. The Department will assign the proper cost avoidance code and scope of coverage. Submit another DHS 6155 containing the old insurance information (include termination date of the policy).

If a corrected Medi-Cal card is required for a current and/or prior months, use EW55 to change the OHC code to a post payment recovery code "A" and issue the corrected Medi-Cal card(s).

When making on-line changes to OHC codes, always send in two DHS 6155s, one containing the old insurance policy information (including the policy's termination date) and the other containing the new insurance policy information.

Be aware that changing the OHC code will delete scope of coverage and health insurance information on the Medi-Cal card. This safety measure is intended to prevent the possibility of the insurance information failing to match the new OHC value.

11. Replacement Card Issuance With Corrected Scope of Coverage Codes

EWs must issue replacement Medi-Cal cards for both county-controlled and SSI/SSP eligible cases when the OHC code is in error. If a beneficiary needs an IMMEDIATE NEED CARD only because the OHC code is incorrect, follow the on-line instructions described in Section 15A (10. MEDS On-Line Other Health Coverage Code Override Process). If the beneficiary needs an IMMEDIATE NEED CARD because the scope of coverage coding is incorrect, proceed as follows:

- If the beneficiary can wait a few days for a card, call the Health Insurance Section at 1-800-952-5294 and request a change to the scope of coverage coding on the Health Insurance System (HIS). Allowing one day for the HIS update, request a Medi-Cal card the next day using the EW45.
- If the beneficiary needs a card the same day, use the EW15 or EW 55 transaction to change the OHC code to an "A" and to issue a Medi-Cal card. This action will suspend HIS so that NO scope of coverage or health insurance is displayed on the IMMEDIATE NEED CARD. In order to report the proper cost avoidance code for the future month on county-controlled cases, initiate an OHC code change using the EW20 or EW30 and send a completed Health Insurance Questionnaire (DHS 6155, revision date 2/90 or later) containing the corrected scope of coverage to the Department. For SSI/SSP cases, send a completed DHS 6155 to the Department. The Department will assign the proper cost avoidance code and update HIS with the corrected scope of coverage.

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## MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

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12. Beneficiary and County Welfare Department Inquiries Regarding Other Health Coverage

Other Health Coverage questions can be answered between 8:00 a.m. and 5:00 p.m., Monday through Friday, by calling the Health Insurance Section's toll-free number, 1-800-952-5294. Spanish speaking operators are also available from 8:00 a.m. to 5:00 p.m., Monday through Friday. Eligibility Workers may give this toll-free number to beneficiaries with the understanding that only health insurance related questions can be answered.



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## MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

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### 15B – MEDI-CAL CASUALTY CLAIMS

County welfare departments are required to notify the Department of Health Services (DHS) when they obtain information that a beneficiary sustained injury for which Medi-Cal may have paid benefits and where the beneficiary or his/her representative has initiated an insurance claim; workers' compensation claim; or wrongful death, malpractice, or similar civil suit against a potentially liable third party.

One important source of information is the Statement of Facts for Medi-Cal (MC 210). Question 9C asks whether an applicant is seeking compensation through an insurance settlement or lawsuit when a physical or emotional problem was caused by an injury. Question 34 also asks whether the applicant or any family member has a pending suit or insurance settlement for accident or injury.

The county must notify DHS of a potential third-party liability claim when:

1. Information on the MC 210 or from other sources indicates potential third-party liability;
2. Eligibility is granted or has been in existence for any length of time; and
3. The beneficiary intends to use Medi-Cal to pay for injury-related services.

All notifications should contain the following information:

1. Medi-Cal beneficiary's name. If a minor, the parents' / guardians' names should also be given.
2. Current address and telephone number.
3. Fourteen-digit Medi-Cal identification number(s) (for example, 19-20-2001246-001). All numbers must be reported; a beneficiary may have had more than one number if the aid category or the Family Budget Unit and person number changed.
4. Social Security Number.
5. Date of Birth.
6. Date of injury.
7. Name, address, and telephone number of third-party recovery source(s) (i.e., attorney, insurance company, etc.).
8. Name, address, and telephone number of treating providers of health care and dates of service (if available).
9. For workers' compensation claims, a copy or the number of the Application for Adjudication of Claim (if available).

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## MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

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Notifications may be reported by calling (800) 952-5776 or (916) 322-0521, or by writing to:

**Department of Health Services  
Casualty/Workers Compensation Section  
P.O. Box 2471  
Sacramento, CA 95811-2471**

In no event should any county agency place liens upon beneficiaries' judgments, settlements, or other assets or in any way attempt to recover from a beneficiary or his/her attorney any amount reimbursable to Medi-Cal in casualty cases.

When the Casualty/Workers Compensation Section receives payment on an account, a written notification is sent to the welfare department of the county in which the beneficiary resides. This is to alert the county that a settlement was reached which may affect the eligibility of the individual.



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**MEDI-CAL ELIGIBILITY MANUAL**  
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STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

GEORGE DEUKERIAN, Governor

**DEPARTMENT OF HEALTH SERVICES**  
CASUALTY/WORKERS' COMPENSATION SECTION  
P.O. BOX 2472  
SACRAMENTO, CA 95811



It is our understanding that the recipient(s) on the enclosed list may have received a cash settlement from a personal injury case which has been recently resolved. The exact amount of cash received, if any, by each recipient is unknown.

This information may assist you in determining the recipient's eligibility for public assistance or Medi-Cal.

If the fifth (5th) digit of the case number is a nine (9), it represents an SSI/SSP recipient.

This letter is sent to both county and Social Security offices.

If you have any questions, please call the toll-free number 1-800-952-5776, between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday.

Enclosure

CWC 4000 (10/83)



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## MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION

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### 15D—MEDICARE GENERAL INFORMATION

#### PART A MEDICARE

- | <u>1. MONTHLY PREMIUMS</u>  | <u>MEDI-CAL PAYMENT ON BEHALF OF THE ELIGIBLE BENEFICIARY</u>   |
|---|---|
| <ul style="list-style-type: none"><li>• No monthly premium under Medicare Part A for most beneficiaries, but:<ul style="list-style-type: none"><li>- Those who buy Medicare Part A pay a monthly Part A premium, and</li><li>- the premium may be higher for those who enroll late.</li></ul></li></ul>       | <ul style="list-style-type: none"><li>• \$221.00 effective 1/93</li></ul>   |
| <h4><u>2. HOSPITAL CARE</u></h4> <ul style="list-style-type: none"><li>• Deductible required upon first admission to a hospital and subsequent admission if next admission is after 60 days from discharge.</li><li>• First 60 days</li><li>• 61st to 90th day</li><li>• Lifetime reserve - 60 days</li></ul> | <ul style="list-style-type: none"><li>• \$676.00 effective 1/93</li><li>• None; fully covered by Medicare for rehabilitation or noncustodial care</li><li>• \$169.00 per day effective 1/93</li><li>• \$338.00 per day effective 1/93</li></ul> |
| <h4><u>3. SKILLED NURSING FACILITY</u></h4> <ul style="list-style-type: none"><li>• First 20 days</li><li>• 21st to 100th day</li></ul>   | <ul style="list-style-type: none"><li>• None; fully covered by Medicare for rehabilitation or noncustodial care</li><li>• \$84.50 per day effective 1/93</li></ul>  |

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## MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION

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### PART B MEDICARE (Supplementary Medical Insurance)

1. MONTHLY PREMIUM • \$36.60 effective 1/93
2. DEDUCTIBLE FOR COVERED SERVICES • \$100.00 per year for 1993
3. MEDICAL INSURANCE BENEFITS • 80 percent of approved charges for covered services after deductible is met

Health Care Financing Administration contracts with Health Maintenance Organization/Competitive Medical Plans (HMO/CMP) to allow certain individuals who are entitled to benefits under Medicare Part B or Parts A and B to elect to receive those benefits through an HMO/CMP. Medi-Cal beneficiaries covered by the Medicare HMO/CMP must use designated facilities. Treatment from non-plan providers must be through arrangements with the plan. Such beneficiaries can be identified by an "F" in the OHC field on MEDS record and on the Medi-Cal card.

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## MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION

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### 15D MEDICARE GENERAL INFORMATION

#### PART A MEDICARE

- | <u>1. MONTHLY PREMIUMS</u>  | <u>MEDI-CAL PAYMENT ON BEHALF OF THE ELIGIBLE BENEFICIARY</u>   |
|---|---|
| <ul style="list-style-type: none"><li>No monthly premium under Medicare Part A for most beneficiaries, but:<ul style="list-style-type: none"><li>- Those who buy Medicare Part A pay a monthly Part A premium, and</li><li>- the premium may be higher for those who enroll late.</li></ul></li></ul> | <ul style="list-style-type: none"><li>\$221.00 effective 1/93</li></ul>   |
| <u>2. HOSPITAL CARE</u>   |   |
| <ul style="list-style-type: none"><li>Deductible required on first admission to a hospital and subsequent admission if next admission is after 60 days from discharge.</li></ul>  | <ul style="list-style-type: none"><li>\$676.00 effective 1/93</li></ul>   |
| <ul style="list-style-type: none"><li>First 60 days</li></ul>   | <ul style="list-style-type: none"><li>None; fully covered by Medicare for rehabilitation or noncustodial care</li></ul> |
| <ul style="list-style-type: none"><li>61st to 90th day</li></ul>  | <ul style="list-style-type: none"><li>\$169.00 per day effective 1/93</li></ul>   |
| <ul style="list-style-type: none"><li>Lifetime reserve - 60 days</li></ul>  | <ul style="list-style-type: none"><li>\$338.00 per day effective 1/93</li></ul>   |
| <ul style="list-style-type: none"><li>First 20 days</li></ul>   | <ul style="list-style-type: none"><li>None; fully covered by Medicare for rehabilitation or noncustodial care</li></ul> |
| <ul style="list-style-type: none"><li>21st to 100th day</li></ul>   | <ul style="list-style-type: none"><li>\$84.50 per day effective 1/93</li></ul>  |

#### PART B MEDICARE (Supplementary Medical Insurance)

- |   |   |
|---|---|
| <u>1. MONTHLY PREMIUM</u>                 | <ul style="list-style-type: none"><li>\$36.60 effective 1/93</li></ul>  |
| <u>2. DEDUCTIBLE FOR COVERED SERVICES</u> | <ul style="list-style-type: none"><li>\$100.00 per year for 1993</li></ul>  |
| <u>3. MEDICAL INSURANCE BENEFITS</u>      | <ul style="list-style-type: none"><li>80 percent of approved charges for covered services after deductible is met</li></ul> |



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## MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION

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### 15E AGED ALIENS INELIGIBLE FOR MEDICARE

#### BACKGROUND

Section 1836 (2) of the Social Security Act provides that any alien age 65 or older, who is not entitled to monthly Social Security Retirement/Disability (Title II) benefits or Railroad Retirement Benefits, must be a lawfully admitted resident of the United States with five (5) years continuous residence to be eligible for purchase of Medicare Part B coverage.

When confirmation of Medicare eligibility is received through Buy-In or the Beneficiary and Earnings Data Exchange (BENDEX), the Medi-Cal Eligibility Data System (MEDS) record is automatically coded to indicate Medicare eligibility (codes 1, 2, 3, 4, or 5 in the first and/or second digit of the Medicare status). In both situations, the beneficiary's Medi-Cal card is coded to indicate Medicare coverage, and providers are required to bill Medicare prior to billing Medi-Cal for services provided to these beneficiaries.

#### SUPPLEMENTAL SECURITY INCOME (SSI) ALIENS

Alien information from the State Data Exchange (SDX) file identifies aged aliens eligible for Supplemental Security Income (SSI). These eligibles are coded with a 99 alien indicator on the Medicare status line of MEDS to suppress printing of the Medicare indicator code on the Medi-Cal card. This process uses the Alien Code and the Immigration and Naturalization Service (INS) Entry Date from the SDX file. If there is no INS Entry Date, a date is established using the Medi-Cal date of eligibility from the SDX record.

SSI/SSP eligibles also include some aged aliens who are not entitled to Medicare. If such persons come to county offices because their Medi-Cal card erroneously shows Medicare coverage, counties are to report the situation using the State Buy-In Problem Report (Medicare Part A and B) DHS 6166 (4/90). This form is to be forwarded to the Premium Payment Unit.

Based upon county input, the Premium Payment Unit will update MEDS so Medi-Cal cards for these persons are not coded showing Medicare entitlement. The INS Entry Date is used to determine when the 5 year residency is met so action can be taken to attempt Medicare Buy-In. Semi-annually, an Alien Register (list of all aliens meeting the 5 year residency requirement) is provided to SSA district offices so beneficiaries can be instructed to apply for Medicare Part B benefits.

#### MEDICALLY NEEDY (MN) ALIENS

Under the previous system, counties reported the Alien Date of Residence (ADOR) into the United States for these aged aliens to the Premium Payment Unit on form DHS 6166 (formerly HAS 8). The Premium Payment Unit updated MEDS to identify the beneficiary as an aged alien (Medicare Status 99) and posted the ADOR. This in turn suppressed the Medicare indicator on the Medi-Cal card until the five year residency requirement was met. The ADOR was used to initiate Buy-In action.

In order for the Premium Payment Unit to determine which beneficiary is eligible for Medicare benefits, counties must now provide alien information when submitting approved case information to MEDS for all county determined cases.

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## MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION

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### COUNTY PROCEDURES

MEDS has three data elements (Refugee/Aged Alien Indicator, INS Entry Date and Eligibility Date) which are reported by counties when submitting case information for all county determined cases. These data elements are used by the State to determine Medicare card coding and whether to attempt Medicare Buy-In.

1. REFUGEE/AGED ALIEN INDICATOR  
(MEDS Name = Aged Alien Indicator)  
(DE 2009)
  - 1 = Indochinese Refugee
  - 7 = Other Refugee
  - 8 = Cuban/Haitian Entrant
  - 9 = Aged Alien
  - \* = Delete Refugee/Alien Information
- a) Codes 1, 7, and 8 are used to identify refugees (previously reported on the MC 255)
- b) Code 9 is used to identify aged aliens who have not met the five (5) year residency requirement.
- c) The asterisk (\*) is used to delete codes incorrectly entered on MEDS.

NOTE: The Refugee/Alien Indicator will suppress Medicare coding on the Medi-Cal card until information is received from HCFA confirming Medicare eligibility.

### 2. INS ENTRY DATE

Counties may report the Alien Code and Date of Entry on MEDS transactions EW15, EW20, EW30, and EW55 online or via batch transactions to update Medicare status and Alien Entry Date on the MEDS file.

(MEDS Name = INS Entry--MMYY)  
(DE 2005)

Refer to Medi-Cal Eligibility Manual Section 14D for instructions on preparing EW transactions.

### 3. ELIGIBILITY APPROVAL DATE

(MEDS Name = ELIG-APPRV--MMYY)  
(DE 9252)

The Eligibility Approval Date is the month and year in which the eligibility worker completed determination and approved the case. (Refer to Medi-Cal Eligibility Manual Section 15F for additional information on determining Eligibility Approval Date).



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## MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION

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### MEDICARE

#### 1. EXPLANATION OF MEDICARE

Medicare, administered by the federal Social Security Administration (SSA), is a Health Insurance program that pays for certain medical services provided to individuals entitled to coverage. It covers the aged (65 and over), blind or disabled (persons eligible for Social Security Disability payments) and persons in need of renal dialysis or transplant. There are two parts to the Medicare program:

- a. Part A Hospital Insurance is available to "insured" persons at no cost and helps pay for inpatient hospital care, some inpatient care in a skilled nursing facility, home health care and hospice care. Those who do not qualify for "free" Part A can purchase such coverage through payment of a monthly premium.
- b. Part B Supplemental Medical Insurance may be purchased from SSA through payment of a monthly premium and helps pay for doctor's services, outpatient hospital services, durable medical equipment, and a number of other medical services and supplies that are not covered by the hospital insurance part of Medicare.

#### 2. MEDICARE HEALTH INSURANCE CARD

Medicare Health Insurance cards are prepared and mailed by SSA and the Railroad Retirement Board (in instances where Railroad Retirement beneficiaries are involved) to beneficiaries who have established entitlement to Medicare benefits.

The red, white and blue card shows the Health Insurance Claim (HIC) number, entitlement to Part A and/or Part B and the effective date of each. The Medicare beneficiary receives a new card each time his/her Medicare eligibility status changes.

#### 3. HEALTH INSURANCE CLAIM (HIC) NUMBER

The HIC number is an important piece of information used by the State and counties to identify an individual's Medicare record. A HIC number must be alpha/numeric and consist of ten to twelve positions. The HIC number must be in Social Security Number (SSN) or Railroad Retirement Board (RRB) number format.

- a. SSN Format: -If the first nine positions are numeric, the HIC number is assumed to be in SSN format. The following criteria must be met:
  - (1) The first nine positions must be numeric.
  - (2) Position 10 must be alphabetic; position 11 must be alphabetic, numeric, or blank; and position 12 must be blank (e.g., 123456789B, 123456789C2, 123456789BP ).

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## MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION

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- b. **RRB Format:** If the first nine positions are not numeric, the HIC number is assumed to be in RRB format. The number consists of a one to three alphabetic character prefix in the first three positions, followed by a six or nine digit number. The following criteria must be met:
- (1) The prefix must be A, H, CA, JA, MA, MH, PA, PD, PH, WA, WD, WH, WCA, WCD, or WCH, left justified (beginning in first position of field) with trailing blanks (if applicable). If the last nine positions are numeric, they must contain a valid SSN (e.g., A 123456789, WC 123456789, WCA123456789).
  - (2) If prefix is a single alpha character, it must be followed by two blanks (e.g., A 123456789). If prefix has two alpha characters, it must be followed by a single blank (e.g., WA 123456789).

### MEDICARE PREMIUM PAYMENT

#### 1. PART B PREMIUM PAYMENT (BUY-IN) PROGRAM

Buy-In refers to the arrangement through which the State uses Medi-Cal funds to pay the monthly Medicare Part B insurance premiums for qualifying Medi-Cal recipients who are also eligible for Medicare.

The Buy-In agreement was initiated to enable the State to obtain maximum Federal Financial Participation (FFP) for Medi-Cal recipients.

Under the Part B Buy-In agreement, the State may begin to pay Part B premiums for qualified Medi-Cal recipients at anytime and is not limited to SSA's defined open enrollment periods. The State may also Buy-In retroactively to the entitlement date of an individual at any time without paying a late enrollment penalty. All Medi-Cal recipients eligible for Medicare Part B coverage are required to participate in the Medicare Buy-In program in accordance with Section 50777 of Title 22 of the California Code of Regulations.

#### 2. PART A PREMIUM PAYMENT

Medi-Cal pays Part A premiums only for OMBs who do not qualify for free Part A and for Qualified Disabled Working Individuals (QDWIs) (refer to Section 15F for a detailed explanation of these programs). Unlike Part B, the State does not have a Buy-In agreement for Part A. The State cannot, therefore, purchase retroactive Part A coverage as it does for Part B under the Buy-In agreement. In addition, enrollment of Medi-Cal recipients is limited to SSA's open enrollment periods.

In instances where the recipient did not apply for Medicare Part A eligibility within his/her seven (7) month Initial Enrollment Period (IEP), the State is assessed a ten percent (10%) penalty for late enrollment. The QDWI program offers a twelve (12) month grace period after the IEP to the State to begin payment of Part A premiums. If the individual enrolls after the twelve (12) months, the State will then be assessed the ten percent (10%) penalty for late enrollment. Once the IEP and any grace period has passed, an individual may enroll only during the General Enrollment Period (GEP) of January through March with eligibility beginning in July.

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## MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION

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### 3. COVERAGE PERIODS

#### A. Medicare Part B Buy-In

(1) Part B Buy-In coverage begins:

(a) For SSI/SSP Recipients

The first month an individual is eligible for both Part B coverage and an SSI/SSP cash payment.

(b) For MN Recipients

The second month after the month in which an individual's eligibility for Medi-Cal is approved, providing the individual is eligible for Part B coverage. Approved, in this context, means the date on which the EW makes the determination that the beneficiary is eligible for Medi-Cal.

(2) Part B Buy-In coverage ends:

(a) The end of the last month for which an individual is eligible for the Medi-Cal program.

(b) The month in which an individual dies.

(c) The end of the last month for which an individual under sixty-five (65) is considered disabled or blind under Social Security.

NOTE: For MN beneficiaries, Buy-in coverage can end no earlier than the second month before the month in which SSA receives the deletion request from the State.

#### B. Medicare Part A

Part A coverage is paid by Medi-Cal for QMBs and QDWIs, not for the regular Medi-Cal population.

(1) QMB Part A coverage begins the month after the month in which an individual is approved for QMB eligibility and meets the following criteria:

(a) Is not entitled to premium free Part A.

(b) Has enrolled in Part A and has met his/her Part A entitlement date.

(2) QDWI Part A coverage begins the first month in which an individual is approved for QDWI eligibility and meets the following criteria:

(a) Is not entitled to premium free Part A.

(b) Has enrolled in Part A and has met his/her Part A entitlement date.

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## MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION

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- (3) Part A coverage ends:
- (a) The end of the last month for which an individual is eligible for the QMB or QDWI program.
  - (b) The month in which an individual dies.
  - (c) The end of the last month for which an individual under sixty-five (65) is entitled to Part A.

### AGENCY RESPONSIBILITIES

The Buy-In Agreement, Premium Payment programs and automated systems are administered jointly by the Health Care Financing Administration (HCFA), the Social Security Administration (SSA), the State Department of Health Services' Premium Payment Unit, and the counties.

1. HEALTH CARE FINANCING ADMINISTRATION (HCFA)

HCFA central office has overall responsibility for administration of the Buy-In Agreement and the Premium Payment provisions of the Social Security Act.

2. SOCIAL SECURITY ADMINISTRATION (SSA)

SSA offices are responsible for determining SSI/SSP eligibility, processing applications for Medicare, providing information about SSA and Medicare benefits and replacing lost or stolen Medicare cards. SSA provides the State with information on SSI/SSP recipients by the way of the State Data Exchange (SDX) file. The State then utilizes this information to establish and maintain Medi-Cal eligibility.

3. PREMIUM PAYMENT UNIT

The Premium Payment Unit maintains the automated Medicare Premium Payment systems which interface with federal Social Security systems and the State Medi-Cal Eligibility Data System (MEDS). The Unit identifies and evaluates Medi-Cal recipients who may be entitled to Medicare benefits, requests additional information from counties if needed, and interacts with SSA to place all qualified Medi-Cal recipients onto the Buy-In, Qualified Medicare Beneficiaries (QMB) and Qualified Disabled Working Individuals (QDWI) programs. The actions of the Premium Payment Unit result in a shift of medical costs from the State/federal Medi-Cal Program to the federal Medicare program.

4. COUNTIES

A. Identifying and Reporting Potential Medicare Eligibles

Counties determine Medi-Cal and/or QMB eligibility and enter data on MEDS. The counties also determine QDWI eligibility and transmit information on potential QDWI eligibles using the Electronic Mail Communication Center/Totally Automated Office (EMC2/TAO) system. The State uses MEDS and QDWI information to identify potential Medicare eligibles. Information such as name, sex, date of birth, Medi-Cal eligibility effective date and the Health Insurance Claim (HIC) number is edited and matched with records at SSA and HCFA

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## MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

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Central Offices to determine whether Medi-Cal eligibles may also qualify for the Medicare program.

### **B. Verification of Data Reported**

Procedures established by CMS require a match of more than one characteristic of an individual's case in order to locate a corresponding record on CMS's Health Insurance Master file. All of the information collected by the county EW must be complete and accurate to be of maximum benefit. It is important to verify that the HIC number is correct by checking the beneficiary's Medicare card. Additionally, when a disabled beneficiary received his/her disability claim number (Title II), it should be reported to MEDS since it can also be used for Buy-In and/or QMB purposes.

### **C. Dealing with Incomplete Information**

If the applicant is unable to provide the county EW with the necessary information (such as age, citizenship, or lawful alien status and residency), the county must assume the burden of establishing the applicant's medical insurance eligibility or refer the case to the Premium Payment Unit. If the applicant refuses to provide information needed to determine Medicare status, the county must deny Medi-Cal eligibility due to lack of cooperation.

### **D. Informing the Beneficiary**

The county EW should advise the applicant of the following:

- (1) By filing an application for Medicare benefits, the individual may establish entitlement to Medicare Part B. If an individual wishes to enroll in the QMB or QDWI programs, he/she must first establish Part A eligibility.
- (2) Refusal to apply for Medicare benefits may result in a denial of Medi-Cal benefits.

### **E. Establishing Medicare Entitlement**

If an applicant has yet to establish Medicare entitlement, the county EW must refer the applicant to the nearest local SSA district office to apply for Medicare benefits. It is very important that the applicant establishes Medicare entitlement so that the State may defer costs of medical services to Medicare.

### **F. Handling Premium Payment Problems**

The Premium Payment Unit is available to assist in resolving county Buy-In, QMB and QDWI problems. Counties are encouraged to use the services of this unit.

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## MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

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To resolve a Buy-In and/or QMB problem that has been detected by a county, complete and forward form DHS 6166 to:

**Department of Health Services  
Medicare Operations Unit  
MS 4719  
P.O. Box 997422  
Sacramento, CA 95899-7422**

To resolve a QDWI problem that has been detected, send all pertinent information to the Premium Payment Unit via the Totally Automated Office (TAO), "E-Mail for QDWI" screen, found in the forms section of TAO.

### **MEDICARE PREMIUM PAYMENT PROCESSES AND SYSTEMS**

Medi-Cal recipients who are eligible for Medicare Part A and/or Part B benefits are identified via the State Medi-Cal Eligibility Data System (MEDS) which is maintained through State, county and federal Social Security Administration (SSA) data input. The State issues a Medi-Cal card each month. From that action, the State Medi-Cal and Medicare Premium Payment systems are alerted and, when appropriate, Premium Payment activity is initiated for eligibility beneficiaries by the State of CMS.

#### **1. MEDICARE PREMIUM PAYMENT SYSTEM**

The month-to-month operations of the Medicare Part B Buy-In and Part A QMB programs are accomplished through an automated exchange of data between the State and SSA. The State computer file, containing accretion and deletion records for potential Medicare eligibles who are on a county-administered Medi-Cal Program, is sent to SSA in Baltimore, Maryland, no later than the 25<sup>th</sup> of each month in order to be included in the next month's Premium Payment update operations.

The Premium Payment Unit maintains the State's Medicare Part B Buy-In and Part A Premium Payment systems which interface with federal Social Security systems and MEDS. These automated systems are designed to pay the Medicare Part B and/or Part A premiums for the Medi-Cal Program. The Qualified Disabled Working individual (QDWI) program is the only program not fully incorporated into MEDS and the automated Buy-In and Premium Payment systems.

#### **2. MEDI-CAL AND MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS) MEDICARE CODING**

The two digit Medicare status codes on MEDS (refer to next page) identify Medicare Part A and/or Part B coverage for eligible Medi-Cal recipients. These codes are translated to a one-digit code on the Medi-Cal card which alerts providers to the type of Medicare coverage available to a beneficiary and is used to determine if Medicare must be billed prior to billing Medi-Cal.

#### **3. COUNTY ALERTS/MESSAGES**

County Alerts/Messages are generated to the counties as part of the monthly processing of the Buy-In Response File received from CMS for Medicare Part A and Part B. These Alerts/Messages provide county staff with a quick reference to the updated status of each eligible beneficiary under

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**MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION**

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his/her control without having to access MEDS. Alerts/Messages are sorted in the sequence each county has requested. Messages are generated only for current active county-controlled recipients or for OMBs.

The following is a Summary Table of the Buy-In County Alerts/Messages each county receives:

**COUNTY ALERTS/MESSAGES**

Alert Number	Alert	Response
8003	HIC-NO CHANGED BY PREMIUM PAYMENT UNIT OR SSA	SEE APPENDIX 2
8004	CLOSED PERIOD ACCRETION	NO RESPONSE NECESSARY
8005	DISABLED BUT NOT YET ELIGIBLE FOR MEDICARE	NO RESPONSE NECESSARY
8006	ACCRETION FAILED HCFA MATCH CRITERIA	SEE APPENDIX 2
8007	STATE INITIATED ACCRETION	NO RESPONSE NECESSARY
8008	FED INITIATED, STATE CONTROLLED ACCRETION	NO RESPONSE NECESSARY
8009	FED DELETION; INELIGIBLE FOR MEDICARE	SEE APPENDIX 2
8010	STATE INITIATED DELETION	NO RESPONSE NECESSARY
8011	FED INITIATED DELETION	NO RESPONSE NECESSARY

Message Number	Message	Response
9004	ACTIVE MEDI-CAL RECIPIENT - DECEASED PER HCFA BUY-IN	SEE APPENDIX 2
9005	ACTIVE MEDI-CAL RECIPIENT - OUT-OF-STATE PER HCFA BUY-IN	SEE APPENDIX 2
9006	OMB ELIGIBLE - BUY-IN REJECTED - NO PART A ENTITLEMENT	SEE APPENDIX 2

County Alerts/Messages

**8003 HIC-NO CHANGED BY PREMIUM PAYMENT UNIT OR SSA**

This alert informs county staff that either SSA or the Premium Payment Unit has changed the beneficiary's HIC number on MEDS. Data elements associated with this alert display the new HIC number from the transaction, the old HIC number from MEDS, and the HIC-SOURCE.

**RESPONSE:** County records should be updated to reflect the new HIC number so that if eligibility is terminated and later re-established, the latest HIC number will be reported to MEDS.

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### 8004 CLOSED PERIOD ACCRETION (Part B only)

This is an informational alert to inform county staff that a Buy-In accretion transaction covering a history period has been received from SSA. Data elements associated with this alert display the HIC number and the Buy-In Effective Date.

RESPONSE: No response necessary.

### 8005 DISABLED BUT NOT YET ELIGIBLE FOR MEDICARE

This is an informational alert to inform county staff that an accretion transaction was rejected by Baltimore with a status code indicating that the recipient is not yet eligible for Medicare but will be as soon as the waiting period is completed as indicated by the Date of Medicare Entitlement. Data elements associated with this alert display the HIC number and the Date of Medicare Entitlement.

RESPONSE: No response necessary

### 8006 ACCRETION FAILED HCFA MATCH CRITERIA

This alert indicates that an attempt to purchase Medicare coverage was rejected by HCFA because the recipient identification information did not match any record on HCFA's Health Insurance Master File. Data elements associated with this alert display the HIC number and the Buy-In Effective Date. MEDS will initiate a Buy-In accretion for anyone in a potential Medicare covered aid code who is not identified as a Medicare ineligible alien and either:

- A. has a HIC number on MEDS;
- B. is age sixty-five (65) or over, or,
- C. is eligible in a blind or disabled aid category.

If the accretion attempt did not match a record on HCFA's Health Insurance Master File, the system is unable to confirm whether or not the Medi-Cal recipient is entitled to Medicare.

RESPONSE: The response will vary depending on the following circumstances:

- A. If the recipient is sixty-five (65) years of age or over, and:
  - 1. recipient is an aged alien who is ineligible for Medicare, enter the Immigration and Naturalization Service (INS) entry date and the alien indicator code of 9 directly onto MEDS. This process will suppress Medicare indicator coding on the Medi-Cal card;
  - 2. recipient has not yet applied for Medicare coverage, notify the recipient of the requirement to apply for Medicare coverage as a condition of Medi-Cal eligibility; or
  - 3. neither 1. nor 2. apply, check for problems as noted under item 2 below.



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## MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION

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- B. If the recipient is a dialysis eligible or if you have information confirming that the recipient is either receiving Social Security disability benefits (Title II) or is entitled to Medicare coverage; and
1. the HIC number and/or sex on MEDS is incorrect, submit a correction to update MEDS using the appropriate EW transaction;
  2. the name and/or birthdate on MEDS does not match information on the recipient's Medicare Card or his/her disability (Title II) award letter from SSA, report the name and birthdate information from the Medicare Card or award letter to the Premium Payment Unit on Form DHS 6166 to update the alternate name/birthdate information on MEDS; and,
  3. neither 1. nor 2. apply, report that information to the Premium Payment Unit on Form DHS 6166. The Premium Payment Unit will contact SSA to resolve the problem that is preventing the Premium Payment accretion from matching HCFA's file.
- C. When the recipient is under 65, is not receiving Social Security disability benefits (Title II), is not entitled to Medicare coverage; and
1. the HIC number displayed with this message is blank, no action is required;
  2. the HIC number displayed with this message is not blank, submit the appropriate EW transaction to remove the HIC number from MEDS.

### 8007 STATE INITIATED ACCRETION

This alert informs county staff that a State initiated Buy-In accretion transaction was accepted by HCFA. Data elements associated with this alert display the HIC number and the Buy-In Effective Date.

RESPONSE: No response necessary.

### 8008 FED INITIATED, STATE CONTROLLED ACCRETION

This is an informational alert to inform county staff that an accretion transaction was initiated by HCFA. A HCFA initiated accretion action normally results either from a complaint or from a Medicare applicant reporting Medi-Cal eligibility. The data elements associated with this alert display the HIC number and the Buy-In Effective Date.

RESPONSE: No response necessary.

### 8009 FED DELETION INELIGIBLE FOR MEDICARE

This alert informs county staff that a deletion transaction was initiated by HCFA because, according to HCFA, it appears that the Medi-Cal recipient does not meet eligibility requirements for Medicare. Data elements associated with this alert display the HIC number and the Buy-In Effective Date.

RESPONSE: If the Medi-Cal recipient believes that he/she is entitled to Medicare, refer recipient to an SSA district office.

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## MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION

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### 8011 FED INITIATED DELETION

This is an informational alert to inform county staff that a deletion transaction was initiated by HCFA based on either a complaint, a problem memorandum or other written request to terminate Medicare Part A and/or B. Data elements associated with this alert display the HIC number and the Buy-In Effective Date.

RESPONSE: No response necessary.

### 9004 ACTIVE MEDI-CAL RECIPIENT - DECEASED PER HCFA

This alert informs county staff that either a State initiated accretion transaction was rejected by HCFA or HCFA initiated a deletion transaction because, according to HCFA, this beneficiary is deceased. MEDS shows this beneficiary as a currently active Medi-Cal recipient. Data elements associated with this alert display the HIC number and the Buy-In Effective Date.

RESPONSE: County staff should verify whether the recipient is in fact deceased and, if so, terminate Medi-Cal eligibility. If the recipient is not deceased, refer recipient to an SSA district office to correct the problem.

### 9005 ACTIVE MEDI-CAL RECIPIENT - OUT-OF-STATE PER HCFA

This alert informs county staff that, according to HCFA, this recipient has changed the state of residence to a state other than California. MEDS shows this recipient as a currently active Medi-Cal recipient. The data elements associated with this alert display the HIC number and the Buy-In Effective Date.

RESPONSE: County staff should verify if the recipient has moved out of state and, if so, terminate Medi-Cal eligibility. If the recipient has not moved out of state, refer recipient to an SSA district office to correct the problem.

### 9006 QMB ELIGIBLE - BUY-IN REJECTED - NO PART A ENTITLEMENT

This alert informs county staff that the State's accretion attempt for Part B Buy-In for a QMB eligible has been rejected by HCFA because, according to HCFA, this recipient is not entitled to Medicare Part A. Non-entitlement to Medicare Part A would make a recipient ineligible as a QMB. Data elements associated with this alert display the HIC number and the Buy-In Effective Date.

RESPONSE: County staff should verify if the recipient has confirmation of Part A entitlement and, if not, terminate QMB eligibility. If the recipient believes that he/she is currently entitled to Medicare Part A Benefits, refer recipient to an SSA district office to correct the problem. If the recipient does have confirmation of Part A entitlement, send proof of Part A entitlement along with a DHS 6166 complaint form to the Premium Payment Unit.

\* NOTE: MEDS alerts that read "Potential Medicare Buy-In age 64 years 9 months or over" are generated for county information and use. County EWs should either assist the Medi-Cal recipient to enroll into the Medicare Part B Buy-In Program or enter the INS entry date and alien code 9 on MEDS.

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### 6. DATA EXCHANGE WITH SSA

The State processes Medicare Part B Buy-In, QMB and QDWI tapes for transmission to Baltimore Data Processing (BDP). Accretions/deletions are processed in BDP around the 25th calendar day of each month. HCFA initiates actions for Part B SSI beneficiaries; the State is responsible for non-SSI beneficiaries, QMBs and QDWIs. A separate file, Third Party Master (TPM), is maintained by BDP to control premium billing to states and other third-party payors. These tapes contain accretions, deletions or changes for Buy-In, QMB and QDWI beneficiaries.

### BUY-IN EFFECTIVE DATE FOR MEDICALLY NEEDY (MN) PERSONS

In order to comply with Federal requirements for determining the Buy-In effective date, counties must report Medi-Cal approval date to MEDS for potential Buy-In of MN recipients. This approval date is required for each new period of MN eligibility that is not contiguous with prior eligibility. (Prior eligibility can include Supplemental Security Income/State Supplemental Program or Aid to Families with Dependent Children cash eligibility which automatically conferred Medi-Cal eligibility).

Buy-In coverage for a qualified Aged, Blind or Disabled MN eligible beneficiary begins the second month after the month in which Medi-Cal eligibility is approved for medical assistance, unless the individual was a Public Assistance (PA) or other PA eligible in the month immediately preceding the month in which MN eligibility began. The two month lag time for an MN Eligible Beneficiary is automatically calculated by the State from the date of eligibility approval by the county. When a beneficiary receiving Medicare changes from PA to MN status, there should be continuous Buy-In and the two month lag time does not apply.

Approval date means the month and year in which the Eligibility Worker (EW) makes the determination that the beneficiary is eligible for Medi-Cal. For example, an applicant applies for Medi-Cal on May 5, 1992, requesting retroactive coverage to February 1992. On June 20, 1992, the EW determines the applicant is eligible retroactive to February 1992. The approval date in this case is June 1992.

The approval date should be reported on EW05, EW20 or EW30 transactions which establish new MN eligibility on MEDS: (1) when the recipient is a potential Medicare eligible (aged, blind, or disabled, including chronic renal disease); or, (2) the recipient is AFDC-MN and either has a valid HIC number with an "A", or "H" prefix; or an A, J1-J4, M, M1 or T suffix, or is over age 65.

Any overstated shares of cost resulting from the "third month" Buy-In assumption (i.e., assumption that Buy-In will occur in the second month after the month in which eligibility is approved) can be adjusted in later months as provided in Title 22, Section 50653.3. Adjustments should however, be minimal.

### QUALIFIED DISABLED WORKING INDIVIDUALS (OWDI) PROGRAM

Section 6408(d) of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) requires that the State pay Part A Medicare premiums for individuals who lost Title II and Medicare benefits due to earned income above the required Substantial Gainful Activity (SGA) limit beginning July 1, 1990. Unlike the Qualified Medicare Beneficiary Program (QMB), States are not required to pay coinsurance and deductibles or the Part B premium. A QDWI is eligible to enroll in premium Medicare Part A Hospital Insurance, under a special program and:

- o has not attained age 65;

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- o has been entitled to disability insurance benefits under Title II;
- o continues to have a disabling physical or mental condition;
- o has lost Title II benefits due to earnings exceeding the SGA limits;
- o is not otherwise entitled to Medicare;
- o whose income does not exceed the income level established at an amount of 200% of the federal income poverty line;
- o whose resources do not exceed twice the SSI standard; and
- o who is not otherwise eligible for medical assistance under Title XIX (except see discussion under 4. Dual Eligibility).

A QDWI is considered a Medi-Cal recipient and must meet all other conditions of eligibility such as filing an application, residency, citizenship, status reporting, etc.; therefore, an OBRA alien is not eligible for QDWI benefits.

### 1. REPORTING ELIGIBILITY

Due to the small number of QDWI eligibles, MEDS will not carry QDWI records, nor issue the QDWIs Medi-Cal cards. Instead QDWI records will be established by county reporting eligibility using the MEDS Electronic Mail System and maintained manually by the Premium Payment Unit. QDWI beneficiaries will use a Medicare card issued by the Social Security Administration to obtain covered medical care.

County workers should report QDWI eligibility to the Premium Payment Unit via the EMC2/TAO form screen no later than the 17th of the month. The Premium Payment Unit will then notify Health Care Financing Administration (HCFA) of QDWI accretions and deletions by the 25th of the month. The Premium Payment Unit will then notify the county EW, through E-Mail, when HCFA confirms an accretion/deletion. Counties may contact the Premium Payment Unit regarding status on QDWIs or to correct or revise a QDWI record. Use the E-Mail address "Buy-In".

### 2. RETROACTIVITY

Counties will be able to grant three-month retroactive benefits to eligible individuals. QDWI eligibility effective dates cannot, however, be prior to July 1990, when the program went into effect.

### 3. E-MAIL SCREEN

Following is a copy of the "E Mail for QDWI" screen and its instructions. To access the EMC2/TAO screen for QDWIs, sign on through MEDS. At the EMC2/TAO User Menu, select option "B" or bulletin board. The QDWI form is located under option "Forms". The first screen to appear will be the "E-Mail for QDWI" screen. Complete all applicable fields. A second screen provides instructions for adding or deleting eligibles within the required fields.

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### 4. DUAL ELIGIBILITY

The Department of Health Services (DHS) will pay Medicare Part A premiums from State funds for Dually Eligible QDWIs (individuals receiving Medi-Cal after meeting their share of cost or without a share of cost), thus allowing coverage of this group.

### 5. MEDICARE PART A ENROLLMENT PERIODS

The Medicare Part A Initial Enrollment Period (IEP) for a QDWI begins with the month in which the individual receives notice that his/her Part A benefits under the regular Medicare program will end due to excess earnings and ends 7 months later.

For those enrolling during the IEP, benefits begin either the first day of the second month after the month of enrollment, or the first day of the third month, depending on when the individual enrolls. If the individual fails to enroll for Medicare Part A benefits during the IEP, he/she must wait until the General Enrollment Period (GEP) of January through March. Those who enroll in the GEP will not receive benefits until July.

### 6. WHEN ENTITLEMENT ENDS

Medicare entitlement under these provisions ends when an individual is either no longer disabled, requests voluntary termination of the coverage, becomes eligible for Medicare under some other provision (i.e., premium free Medicare), fails to pay the required premiums, or no longer meets eligibility factors.

## QUALIFIED MEDICARE BENEFICIARY (QMB) PROGRAM

Section 301 of the Medicare Catastrophic Coverage Act (MCCA) of 1988 requires the State to pay the Medicare Part A and B cost sharing expenses for certain low income Medicare beneficiaries. Cost sharing expenses are:

- o Premiums (\$221.00 for Part A, if not available free, and \$36.60 for Part B in 1993);
- o Deductible (\$676.00 for Part A and \$100.00 for Part B in 1993); and
- o Coinsurance fees in Part A and B.

Due to the need for State legislation, California was granted a waiver to delay implementation of the QMB program until January 1, 1990.

### 1. QMB ELIGIBILITY CRITERIA

- A) Meet the QMB property requirements under the regular Medi-Cal program or have net nonexempt property, as determined for a QMB, at or below twice California's regular Medi-Cal property limits;
- B) Meet the QMB income standard. That is, a QMB must have net nonexempt income at or below 100% of the federal poverty level;
- C) Be eligible for Part A Medicare hospital insurance with or without a premium; and,

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- D) Be otherwise eligible for Medi-Cal, i.e., meet all other Medi-Cal requirements such as California residency and linkage (e.g., being aged, blind, disabled).

### 2. QUALIFIED MEDICARE BENEFICIARIES

There are two groups of QMBs:

#### A. QMB Dual;

Those receiving regular, full scope Medi-Cal either as cash grant recipients (e.g., Supplemental Security Income/State Supplemental Program (SSI/SSP)) or Medically Needy (MN) beneficiaries. These eligibles already meet the Medi-Cal property limits (QMB property limits are two times the Medi-Cal property limits) and must be determined to meet the QMB income requirement. This group is dually eligible (i.e., eligible for regular Medi-Cal and QMB benefits),

#### B. QMB Only;

Those eligible as QMB Only do not want regular Medi-Cal or are not eligible for regular Medi-Cal due to property above the regular Medi-Cal property limits but not in excess of the QMB property limits.

### 3. AID CODE

Aid code 80 was established as the aid code to identify QMB eligibility. Dual eligibles will have both a regular Medi-Cal aid code and the QMB aid code. QMB Only eligibles will have just the QMB aid code. The indicator "QMB" in the Special Program 1 segment of MEDS is used to show QMB eligibility.

### 4. MEDICARE PART A AND B ENROLLMENT PERIODS

#### A. Part A Enrollment

- 1) If an individual is not already receiving Medicare Part A, application for Part A can be made only:
  - a. During the Initial Enrollment Period (IEP):
    - o No earlier than three months before age 65 but no later than three months after the individual's 65th birthday.
    - o After 24 months of receiving Title II disability benefits, to be effective in the 25th month.
    - o When receiving dialysis related health care services (including renal transplants) at any age.
  - b. During the Special Enrollment Period (SEP), which is the month after an individual stops working if he/she is over 65.

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- c. During the General Enrollment Period (GEP) of January - March to be effective the following July, for a Medicare beneficiary who did not enroll in an IEP or SEP. Such eligibles must apply at the Social Security Administration (SSA) office during the GEP. If they fail to do so, they would have to wait until the next year's GEP and would not be eligible for Part A Medicare and therefore QMB until July of that year.

- 2) Penalties

An individual who does not apply for Part A at the first opportunity is charged a 10% penalty by SSA. Under the QMB program, the State will pay the penalty for a Medicare beneficiary's late enrollment in Part A.

- B) Part B Enrollment

- 1) Part B enrollment criteria for an individual not on Buy-In are the same as for Part A enrollment; however, for those individuals who are Medi-Cal and/or QMB eligible, the GEP, SEP or IEP is waived. The State may begin paying the Part B premium after conditions of eligibility are met (i.e., benefits for a QMB Only begin no earlier than the month after the date of county approval).
- 2) There are Part B penalties for late enrollment similar to those of late enrollment for Part A; however, under the Buy-In agreement, the State is not charged a penalty for Medicare beneficiaries who would otherwise be assessed a penalty for late enrollment in Part B.

### 5. QMB BENEFITS EFFECTIVE DATE

QMB benefits may be effective the first of the month following the date of approval (i.e., first of the month following the date the county makes the determination of eligibility) if:

- A) Beneficiary is already enrolled in Part A; or
- B) Beneficiary enrolls in Part A during his/her IEP or SEP. If a beneficiary enrolls in Part A during the GEP, QMB benefits may be effective the following July. There are no retroactive QMB benefits.

### 6. PART A AND B COVERAGE ENDS

- A) The end of the last month during which an individual is eligible for the QMB program; or,
- B) The end of the month in which an individual dies.

### 7. FEDERAL FINANCIAL PARTICIPATION

Although Medi-Cal pays Medicare Part B premiums, or "Buys-In", for Medically Needy (MN) beneficiaries because it is cost effective, the Medi-Cal Program currently does not receive Federal Financial Participation (FFP) in Part B premiums for MNs. With the implementation of the QMB program, FFP is available for MNs who are also eligible for the QMB program. Thus, it is to the

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State's advantage to enroll MN individuals with free Part A as OMBs, if eligible. The State receives FFP for payment of all Part A premiums.

### MEDICARE CODING. MEDI-CAL CARDS AND MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

Medicare coding on MEDS is determined from information on the MEDS Medicare Buy-In information screen, MEDS BENDEX Title II information screen and MEDS Miscellaneous screen. Counties are not able to directly input or change the Medicare Coding on the MEDS Medicare Status Line. However, if a coding error is detected, Eligibility Workers (EW) should detail the problem on the State Buy-In Problem Report Form (DHS 6166) and send it to the Premium Payment Unit (see Section 15F "Reporting Problems to the State's Premium Payment Unit").

#### 1. MEDICARE CODING ON MEDS

The MEDS Medicare Status Line shows Medicare Part A and Part B entitlement information as well as whether a premium is required and who pays the premium.

The MEDS Medicare Status codes are shown below. The left digit indicates the Medicare Part A status, while the right digit indicates the Medicare Part B status.

<u>PART A</u>	<u>PART B</u>
Blank/O - No Medicare Part A	Blank/O - No Medicare Part B
1 - Paid by Beneficiary	1 - Paid by Beneficiary
2 - Paid by State	2 - Paid by State
3 - Free	3 - Not Applicable
4 - Not applicable	4 - Paid by Other Entity
5 - BI Reject, BENDEX Eligible 1/	5 - BI Reject, BENDEX Eligible 1/
6 - BI Reject, Presumed Eligible 1/	6 - BI Reject, Presumed Eligible 1/
7 - Presumed Eligible	7 - Presumed Eligible
8 - BI Reject, Not Presumed Eligible 1/	8 - BI Reject, Not Presumed Eligible 1/
9 - Alien	9 - Alien

1/ BI Reject means a rejection by Social Security Administration (SSA) of the State's attempt to Buy-In.



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### 2. MEDICARE CODING ON MEDI-CAL ID CARDS

The Medicare Indicator codes which appear on the Medi-Cal ID cards are shown below. The Automated Eligibility Verification System which answers provider inquiries regarding Medi-Cal eligibility also uses the following codes:

Blank	-	No Medicare Coverage
1	-	Medicare Part A Coverage Only
2	-	Medicare Part B Coverage Only
3	-	Medicare Part A and B Coverage

This coding alerts providers to the type of Medicare coverage for which the recipient is eligible so they can determine if Medicare should be billed prior to billing Medi-Cal. For example, if the recipient's Medi-Cal card shows an indicator of "1" (Part A only), a hospital will know it must bill Medicare for inpatient services.

### 3. HAND TYPED CARDS

In those rare instances where counties are required to hand type an MC 301 Medi-Cal card, the following procedures should be followed:

- o If the beneficiary is over 65 years old and has not met the 5 year residency requirement, leave the Medicare Indicator blank to indicate no Medicare entitlement. If he or she is not identified as an alien, Medicare Part B eligibility is presumed, so use an indicator of "2";
- o Use a Medicare Indicator of "1" if the beneficiary has proof of entitlement from Medicare Part A only; and,
- o Use a Medicare indicator of "3" if the beneficiary has proof of eligibility from Medicare for both Part A and Part B.

### REPORTING PROBLEMS TO THE STATE'S PREMIUM PAYMENT UNIT

The Department of Health Service's Premium Payment Unit is available to assist in resolving county Buy-In problems. Each county is encouraged to use the services of this unit when regular Buy-In procedures do not accomplish the desired result. Prior to reporting problems to the State's Premium Payment Unit, the MEDS INQB "Buy-In and BENDEX Information" screen should be reviewed for the current Buy-In status.

When incorrect information is discovered in any of the screen's fields, attach a printout of the INQB screen to a State Buy-In Problem Report (DHS 6166), enter the nature of the error and the correct information in the "Remarks" section of the form and mail to:

State of California  
Department of Health Services  
Medicare Operations Unit  
P.O. Box 997422  
Sacramento, CA 95899-7422

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### COUNTY PROCEDURES FOR COUNTY ADMINISTERED PERSON

In order to resolve a Buy-In problem, provide the following information on the DHS 6166. All data is needed to fully describe the case in question and enable the State to determine the appropriate period of Buy-In eligibility.

1. Health Insurance Claim (HIC) number, Social Security, or RR HIC number.
2. Name.
3. Sex.
4. Date of birth.
5. County code, aid code, case number, family budget unit and person's number (use the appropriate 14-digit case identification for each period of eligibility identified for this individual).
6. Beginning effective date (for each closed period of Medi-Cal eligibility in which there is a discrepancy).
7. Ending effective date (for each closed period of Medi-Cal eligibility in which there is a discrepancy).
8. For Medically Needy recipients, we need the eligibility approval date as described in Section 15F "Buy-In Effective Date for Medically Needy (MN) persons".

### RESOLUTION TIME

Considerable time is needed to correct Buy-In Medicare coding problems. The time required for a problem resolution results from a long sequence of activities involving the processing of an individual problem through county, State and Social Security Administration (SSA) channels and numerous data processing files.

For example, a beneficiary complaining about a premium should expect a minimum wait of four months from the time of the complaint until the billing is corrected by SSA. Once a problem is resolved, a beneficiary must allow SSA 90 to 120 days to refund erroneously deducted or paid premiums.

### SSI BUY-IN PROBLEMS

Refer to Sections 14B and 14E of the Medi-Cal Eligibility Manual for handling of Supplemental Security Income/State Supplementary Payment Medi-Cal card coding problems.

**MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION**

**INQB SCREEN FORMAT AND DEFINITIONS**

The following are the field definitions for the Buy-In and BENDEX segments of the INQB screen:

**MEDS BUY-IN AND BENEFICIARY AND EARNINGS DATA EXCHANGE (BENDEX) INQUIRY (INQB) SCREEN**

This MEDS screen (example shown below) provides various data to assist county staff in determining the Buy-In status of Medi-Cal eligibles. Refer to Appendix 1 for INQB Screen Definitions.

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INQB      ** BUY-IN AND BENDEX INFORMATION **

MEDS-ID          NAME          MEDS-CUR-MMY
=====
===== MEDICARE PART "B" BUY IN INFORMATION=====
A. HIC-NO        D. HIC-SOURCE      F. BUY-IN-ELIG-CD
B. CUR-BUY-IN-STATUS  E. BUY-IN-EFF-DT   G. LAST-PART-B-CHG
C. DOME-DT

===== MEDICARE PART "A" BUY-IN INFORMATION=====
H. CUR-BUY-IN-STATUS  J. BUY-IN-EFF-DT   K. LAST-PART-A-CHG
I. DOME-DT

===== BENDEX TITLE II INFORMATION=====
L. CLAIM-NO        U. LAST-BENDEX-CHG
M. INITIAL-ENTL-DATE  Q. BENDEX-PAY-STATUS  V. COMMUNICATION-CODE
N. OLD-BENEFIT-AMT $  R. HI-ENTL-DATE      W. SMI-ENTL-DATE
O. CUR-BENEFIT-AMT $  S. HI-TERM-DATE      X. SMI-TERM-DATE
P. DUAL-ENTL-IND      T. HI-OPTION-CD      Y. SMI-CODE
Z. PREMIUM-PAYOR

IN__ ENTER QA,QF,QH,QM,QO,QP,QX,Q1,Q2,XC,XE,XM,XN * ENTER KEY RETURNS TO LIST
    
```

**BUY-IN AND BENDEX INQUIRY (INQB) SCREEN DEFINITIONS**

**1. MEDICARE PART B INFORMATION SEGMENT DEFINITIONS**

**A. HIC-NO (Health Insurance Claim Number)**

This field will show the current HIC number if it was reported by either the county or federal government (for HIC-SOURCE, see letter D); otherwise a blank will show. The HIC number shown may not be the correct HIC number.

**B. CUR-BUY-IN-STATUS (Current Buy-In Status)**

The following is a list of valid Buy-In Status Codes with explanations:

<u>Valid Buy-In Status Codes</u>	<u>Code(s) Explanation</u>
1. State Initiated Accretions	Used by the State to accrete an individual to the State's Buy-In Program. Expect response from

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## MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION

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- |     |  |   |
|-----|--|---|
|     | 61, 62, 63, 64   | HCFA within one month from the current date.  |
| 2.  | State Controlled Accretions<br>1161, 1164, 1165, 1167          | An accretion submitted by the State has been added to the Buy-In Program.   |
| 3.  | State Initiated Deletions<br>50, 51, 53, 81                    | Used by the State to delete an individual from the State's Buy-In Program. Expect response from HCFA within one month from current date.                              |
| 4.  | State Controlled Deletions<br>1750, 1751, 1753, 1781           | A deletion submitted by the State has been dropped from the Buy-In Program.   |
| 5.  | Federal Controlled Accretions 1180                             | Informs the State that HCFA has established a Buy-In record on the Third Party Master (TPM) File for an SSI recipient. The accretion was added to the Buy-In Program. |
| 6.  | Federal Controlled Deletions 1500, 1600, 1728, 1759, 1787      | HCFA informs the State that an SSI recipient was deleted from the OMB Part A program.   |
| 7.  | Interim/Special<br>1800, 1900, 3200, 3300, 3662                | Informs the State that although there is no evidence of Medicare entitlement, a claim for Medicare is being developed by Social Security Administration.              |
| 8.  | Rejection (Accretion/Deletion)<br>2100, 2400, 2550, 2560, 2081 | Informs the State that the submitted Buy-In Accretion/Deletion was rejected because of error(s): HIC number, effective date, etc.                                     |
| 9.  | Under investigation<br>3150, 3160                              | Buy-In Accretion/Deletion is under investigation. Expect a response from HCFA within one month from current date.   |
| 10. | DOME<br>2200   | Indicates Prospective Medicare Entitlement (For Date of Medicare Entitlement, see letter C below).  |
| 11. | Alien DOME<br>2290   | Indicates prospective Medicare entitlement for Aged Aliens (For Date Of Medicare Entitlement, see letter C below).  |
| 12. | Blank  | Indicates no Current Buy-In Activity.   |

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## MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION

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C. DOME-DT (Date of Medicare Entitlement) (MM/YY)

This field indicates the prospective Medicare Entitlement Date unless there is termination of Disability Benefits.

D. HIC-SOURCE

For State Use Only. This field contains an internal code that identifies the county, federal or State system through which the HIC number was last reported.

E. BUY-IN-EFF-DT (Effective Date) (MM/YY)

This field indicates Effective month and year, of current Buy-In Status.

F. BUY-IN-ELIG-CD (Eligibility Code)

For State Use Only. This field indicates availability of Federal Financial Participation in the payment of premiums.

G. LAST-PART-B-CHG (Medicare Change Date) (MM/DD/YY)

This field indicates the month and year in which Buy-In activity most recently updated the MEDS record. Buy-In updates occur between the 19th and 25th of the month.

2. MEDICARE PART A INFORMATION SEGMENT DEFINITIONS

H. CUR-BUY-IN-STATUS (Current Buy-In Status)

I. DOME-DT (Date of Medicare Entitlement) (MM/YY)

This field indicates the prospective Medicare Entitlement Data.

J. BUY-IN-EFF-DT (Effective Date) (MM/YY)

This field indicates Effective month and year of current Part A Buy-In Status.

K. LAST-PART-A-CHG (Medicare Change Date) (MM/DD/YY)

This field indicates the month and year in which Part A Buy-In activity most recently updated the MEDS record. Buy-In updates occur between the 19th and 25th of the month.

3. BENDEX TITLE II INFORMATION SEGMENT DEFINITIONS

L. CLAIM-NO

Claim Number or Social Security Number under which SSA benefit is filed.

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## MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION

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**M. INITIAL-ENTL-DATE (MM/YY)**

Initial date of entitlement to Title II benefits.

**N. OLD-BENEFIT-AMT (\$\$\$.cc)**

Net amount previously certified by SSA for payment.

**O. CUR-BENEFIT-AMT (\$\$\$.cc)**

The net amount due the beneficiary under Title II on the 3rd of the next month after the BENDEX record is produced. **EXAMPLE:** The BENDEX file produced on 4/11/90 contained payment information for the 5/3/90 SSA check.

Money amounts are displayed even if the beneficiary was only previously entitled or is in a nonpayment status (see letter Q for current BENDEX-PAY-STATUS). Zeros normally appear if the beneficiary was denied benefits.

**P. DUAL-ENTL-IND**

Indicates whether the beneficiary is or was entitled to SSA Title II benefits under more than one claim number.

Blank No dual entitlement

1. Beneficiary is entitled on more than one claim number and all records are active
2. Indicates the beneficiary has been entitled on more than one claim number and one of the records is now inactive

**Q. BENDEX-PAY-STATUS**

The BENDEX payment status code indicates whether the benefit amount in the CUR-BENEFIT-AMT is payable or the reason it is not payable; a CP in this field indicates that the benefit is payable. Other codes have the following meanings:

A one or two-position code reflecting the SSA payment status for this beneficiary.

**BENDEX Information Definitions**

**Adjustment:**

AA	Withdrawal to split payments
AC	Correction in benefit rate
AD	Adjusted for dual-entitlement
AE	Withdrawn for recomputation
AJ	Worker's compensation offset
AM	Withdrawal from HI-only status; monthly benefits being awarded
AR	Withdrawal from S or T status to place in CP status

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## MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION

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AW	Worker's compensation offset
A&	Withdrawn from nonpayment status to place in CP status
A-	Withdrawn from CP status to be placed in nonpayment status
AO,A1,A2,	Rate reduction is being figured
A3,A4,A5	
A6,A7,A8	
A9	Miscellaneous adjustment not separately defined
Abatement:	
B	Claimant died prior to entitlement
Current Payment:	
CP	Current Payment Status
Deferred:	
DP	Receipt of public assistance
DW	Receipt of worker's compensation
DI	Engaging in foreign work
D2	Beneficiary overpaid because of work
D3	Auxiliary's benefits withheld because of D2 status for primary beneficiary
D4	Failure to have child in care.
D5	Auxiliary's benefits withheld because of a DI status for primary beneficiary
D6	Deferred to recover overpayment for reason not attributable to earnings
D9	Miscellaneous deferment
Denied:	
N	Disallowed claim
ND	Disability claim denied for non-medical reason
Delayed:	
K	Advanced filing for deferred payment
L	Advanced filing
P	Adjudication pending
PB	Benefits due but not paid
PT	Claim terminated from delayed status
PF,PH,PJ,	The beneficiary is to be placed in S payment status upon final adjudication.
PK,PL,PM	The low order position has the same meaning as the corresponding low
PP,PW,PO	order of payment status S. Upon final adjudication
P1,P2,P3	
P4,P5,P6,	
P7,P8,P9	
Suspended:	
SO	Determination of continuing disability is pending
S1	Beneficiary engaged in work outside the U.S.
S2	Beneficiary is working in the U.S. and expects to earn in excess of annual allowable limit
S3	Auxiliary's benefits withheld because of S2 status of primary beneficiary
S4	Failure to have child in care
S5	Auxiliary's benefits withheld due to S1 status for primary beneficiary

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## MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION

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S6 Check was returned - correct address being developed  
S7 Disabled beneficiary suspended due to refusal of vocational rehabilitation; imprisoned; extended trial work period  
S8 Suspended while payee is being determined  
S9 Suspended for reason not separately defined  
SD Technical entitlement only. Beneficiary is entitled on another claim  
SF Special age 72 beneficiary fails to meet residency requirement  
SH Special age 72 beneficiary is receiving a government pension  
SJ Alien suspension  
SK Beneficiary has been deported  
SL Beneficiary resides in a country to which checks cannot be sent  
SM Beneficiary refused cash benefits (entitled to HI-SMI only)  
SP Special age 72 beneficiary suspended due to receiving public assistance  
SS Post secondary student summer suspension  
SW Suspended because of worker's compensation

**Terminated:**

TA Terminated prior to entitlement  
TB Mother, father terminated because beneficiary is entitled to disabled widow(er)'s benefits  
TC Disabled widow attained age 62 and is not entitled as an aged widow  
TJ Advanced filed claim terminated after maturity  
TL Termination of post secondary student  
TP Terminated because of change in type of benefit or post entitlement action  
T& The claim was withdrawn  
T- Converted from disability benefits to retirement benefits upon reaching age 65  
TO Benefits are payable by some other agency  
TI Terminated due to death of the beneficiary  
T2 Auxiliary terminated due to death of the primary  
T3 Terminated due to divorce marriage or remarriage of the beneficiary  
T4 Child attained age 18 or 22 and is not disabled; mother/father terminated because last child attained age 18  
T5 Beneficiary entitled to other benefit  
T6 Child is no longer a student or disabled; or the last entitled child died or married  
T7 Child beneficiary was adopted; mother/father terminated as last child adopted  
T8 Primary beneficiary no longer disabled; or the last disabled child no longer disabled  
T9 Terminated for reason not separately defined

**Uninsured:**



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## MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION

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U Beneficiary is entitled only to HI or SMI

Withdrawal:

W Withdrawal before entitlement

Other Adjustment or termination status:

XO Claim transferred to RRB

X1 Beneficiary died

X5 Entitled to other benefits

X7 HIB/SMIB terminated

X8 Payee is being developed

X9 Terminated for reason not separately defined

XD Withdrawn for adjustment

XF Entitlement transferred to another PSC

XK Beneficiary deported

XR Withdrawn from SMIB

R. HI-ENTL-DATE (MM/YY)

This field will show the current date of entitlement to Hospital Insurance (HI) Part A benefits

S. HI-TERM-DATE (MM/YY)

This field will show the most recent termination date from HI benefits

T. HI-OPTION-CD

This field will show the current HI status code

C No (cessation of disability)

D No (denied)

E Yes (automatic entitlement, no premium necessary)

F No (terminated for invalid enrollment or enrollment voided)

G Yes (good cause)

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**MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION**

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- H No (not eligible for free health insurance benefits (Part A))
- P Railroad jurisdiction
- R No (refused free Part A)
- S No (no longer under renal disease provision)
- T No (terminated for non payment of premiums)
- W No (withdrawal from premium Part A)
- X No (Part A terminated because of Title II termination (Section 2268))  
Supplemental insurance medical benefits (Part B) unchanged
- Y Yes (premium is payable)

**U. LAST-BENDEX-CHG (MM/DD/YY)**

The last date, month, day and year, BENDEX updated MEDS.

**V. COMMUNICATION-CODE MATCHED**

This information is supplied by SSA to help the State analyze records returned in response to State direct input, records being accreted through the Buy-In System, and records previously established as BENDEX which are undergoing change.

Alpha Numeric Codes derived by the BENDEX system to help the State interpret the data received.

Codes for  
fully processed  
records

- WASbXXXb BENDEX exchange is transferred to your agency: Agency XXX will no longer receive BENDEX exchange. See CFbXXXbb below.
- MATCHEDb Current data was extracted from the Master Beneficiary Record (MBR).
- REPbPAYE This is a fully processed record with current data extracted from the MBR. The check is payable to someone other than the beneficiary.
- FINbMMYY The benefits for this beneficiary terminated for the month indicated. If earnings data was requested, it will be sent.
- XREFbNUM Beneficiary is terminated on this record; there is no cross reference MBR or other entitlement.

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## MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION

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UTLbXREF Pertinent data was extracted on this claim number. No MBR has been located however, for a cross-reference number.

CFbXXXbb Record is in conflict with another agency, XXX. This record represents the last automated data for the receiving agency. Since BENDEX receives input from most States, as well as other SSA systems, a priority of processing has been established to follow in the event multiple actions are received in a month for an individual.

**W. SMI-ENTL DATE (MM/YY)**

This field will show the current date of entitlement to Supplemental Medical Insurance (SMI) Part B benefits.

**X. SMI-TERM-DATE (MM/YY)**

This field will show the most recent termination date from SMI benefits.

**Y. SMI-CODE**

This field will show the current SMI status code:

C No (disability ceased)  
D No (denied)  
F No (terminated for invalid enrollment)  
G Yes (good cause, enrolled in SMI)  
N No (dual technically entitled beneficiary not entitled to SMI)  
P Railroad has jurisdiction and collects the premium  
R No (refused)  
S No (no longer under renal disease provision)  
T No (terminated for nonpayment of premiums)  
W No (withdrawal)  
Y Yes (enrolled in SMI)

**Z. PREMIUM-PAYOR**

Indicates the Entity making the Supplemental Medical Insurance (Part B) Premium Payment. The following is an explanation of legends/codes:

1. CIVIL - Civil Service is billed for SMI premium payments  
2. PRITP - Private Third Party is billed for SMI premiums  
3. RRB - Railroad Board has Jurisdiction  
4. SELF - The beneficiary is responsible for the SMI premium  
5. 010 to 650 - Indicates the State is paying the Part B premium. California's State Code for Part B beneficiaries is 050.

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## MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION

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TABLE OF BENEFICIARY IDENTIFICATION CODES (BICs)

<u>SSA BIC</u>	<u>TYPE OF BENEFIT</u>
A	Primary Claimant
B	Aged Wife, age 62 or over (1st claimant)
B1	Aged husband, age 62 or over (1st claimant)
B2	Young wife, with a child in her care (1st claimant)
B3	Ages wife (2nd claimant)
B4	Aged husband (2nd claimant)
B5	Young wife (2nd claimant)
B6	Divorced wife, age 62 or over (1st claimant)
B7	Young wife (3rd claimant)
B8	Aged wife (3rd claimant)
B9	Divorced wife (2nd claimant)
BA	Aged wife (4th claimant)
BD	Aged wife (5th claimant)
BG	Aged husband (3rd claimant)
BH	Aged husband (4th claimant)
BJ	Aged husband (5th claimant)
BK	Young wife (4th claimant)
BL	Young wife (5th claimant)
BN	Divorced wife (3rd claimant)
BP	Divorced wife (4th claimant)
BQ	Divorced wife (5th claimant)
BR	Divorced husband (1st claimant)
BT	Divorced husband (2nd claimant)
BW	Young husband (2nd claimant)
BY	Young husband (1st claimant)
Range C1 Thru C9	Child (includes minor, student, or disabled child)
Range CA Thru CK	Child (includes minor, student, or disabled child)
D	Aged widow, age 60 or over (1st claimant)
D1	Aged widower, age 60 or over (1st claimant)
D2	Aged widow (2nd claimant)
D3	Aged widower (2nd claimant)
D4	Widow (remarried after attainment of age 60) (1st claimant)
D5	Widower (remarried after attainment of age 60) (1st claimant)
D6	Surviving divorced wife, age 60 or over (1st claimant)
D7	Surviving divorced wife (2nd claimant)
D8	Aged widow (3rd claimant)
D9	Remarried widow (2nd claimant)
DA	Remarried widow (3rd claimant)
DC	Surviving divorced husband (1st claimant)
DD	Aged widow (4th claimant)
DG	Aged widow (5th claimant)
DH	Aged widower (3rd claimant)
DJ	Aged widower (4th claimant)

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**MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION**

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**SSA BIC**

**TYPE OF BENEFIT**

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DK	Aged widower (5th claimant)
DL	Remarried widow (4th claimant)
DM	Surviving divorced husband (2nd claimant)
DN	Remarried widow (5th claimant)
DP	Remarried widower (2nd claimant)
DQ	Remarried widower (3rd claimant)
DR	Remarried widower (4th claimant)
DS	Surviving divorced husband (3rd claimant)
DT	Remarried widower (5th claimant)
DV	Surviving divorced wife (3rd claimant)
DW	Surviving divorced wife (4th claimant)
DX	Surviving divorced husband (4th claimant)
DY	Surviving divorced wife (5th claimant)
DZ	Surviving divorced husband (5th claimant)
E	Mother (widow) (1st claimant)
E1	Surviving divorced mother (1st claimant)
E2	Mother (widow) (2nd claimant)
E3	Surviving divorced mother (2nd claimant)
E4	Father (widower) (1st claimant)
E5	Surviving divorced father (widower) (1st claimant)
E6	Father (widower) (2nd claimant)
E7	Mother (widow) (3rd claimant)
E8	Mother (widow) (4th claimant)
E9	Surviving divorced father (widower) (2nd claimant)
EA	Mother (widow) (5th claimant)
EB	Surviving divorced mother (3rd claimant)
EC	Surviving divorced mother (4th claimant)
ED	Surviving divorced mother (5th claimant)
EF	Father (widower) (3rd claimant)
EG	Father (widower) (4th claimant)
EH	Father (widower) (5th claimant)
EJ	Surviving divorced father (3rd claimant)
EK	Surviving divorced father (4th claimant)
EM	Surviving divorced father (5th claimant)
F1	Father
F2	Mother
F3	Stepfather
F4	Stepmother
F5	Adopting father
F6	Adopting mother
F7	Second alleged father
F8	Second alleged mother
J1	Primary Prouty entitled to health insurance benefits (HIB) (less than 3 quarters of coverage (Q.C.)) (General Fund)

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## MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION

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<u>SSA BIC</u>	<u>TYPE OF BENEFIT</u>
J2	Primary Prouty entitled to HIB (over 2 Q.C.) (Retirement and Survivors Insurance (RSI) Trust Fund)
J3	Primary Prouty not entitled to HIB (less than 3 Q.C.) (General Fund)
J4	Primary Prouty not entitled to HIB (over 2 Q.C.) (RSI Trust Fund)
K1	Prouty wife entitled to HIB (less than 3 Q.C.) (General Fund) (1st claimant)
K2	Prouty wife entitled to HIB (over 2 Q.C.) (RSI Trust Fund) (1st claimant)
K3	Prouty wife not entitled to HIB (less than 3 Q.C.) (General Fund) (1st claimant)
K4	Prouty wife not entitled to HIB (over 2 Q.C.) (RSI Trust Fund) (1st claimant)
K5	Prouty wife entitled to HIB (less than 3 Q.C.) (General Fund) (2nd claimant)
K6	Prouty wife entitled to HIB (over 2 Q.C.) (RSI Trust Fund) (2nd claimant)
K7	Prouty wife not entitled to HIB (less than 3 Q.C.) (General Fund) (2nd claimant)
K8	Prouty wife not entitled to HIB (over 2 Q.C.) (RSI Trust Fund) (2nd claimant)
K9	Prouty wife entitled to HIB (less than 3 Q.C.) (General Fund) (3rd claimant)
KA	Prouty wife entitled to HIB (over 2 Q.C.) (RSI Trust Fund) (3rd claimant)
KB	Prouty wife not entitled to HIB (less than 3 Q.C.) (General Fund) (3rd claimant)
KC	Prouty wife not entitled to HIB (over 2 Q.C.) (RSI Trust Fund) (3rd claimant)
KD	Prouty wife entitled to HIB (less than 3 Q.C.) (General Fund) (4th claimant)
KE	Prouty wife entitled to HIB (over 2 Q.C.) (RSI Trust Fund) (4th claimant)
KF	Prouty wife not entitled to HIB (less than 3 Q.C.) (General fund) (4th claimant)
KG	Prouty wife not entitled to HIB (over 2 Q.C.) (RSI Trust Fund) (4th claimant)
KH	Prouty wife entitled to HIB (less than 3 Q.C.) (General Fund) (4th claimant)
KJ	Prouty wife entitled to HIB (over 2 Q.C., (RSI Trust Fund) (5th claimant)
KL	Prouty wife not entitled to HIB (less than 3 Q.C.,) (General Fund) (5th claimant)
KM	Prouty wife not entitled to HIB (over 2 Q.C.) (RSI Trust Fund) (5th claimant)
M	Uninsured beneficiary (not qualified for automatic HIB)
M1	Uninsured beneficiary (qualified for automatic HIB but requests only SMIB)
T	<ul style="list-style-type: none"> <li>• Fully insured beneficiaries who have elected entitlement only to HIB (usually but not always along with SMIB)</li> <li>• Uninsured beneficiary or renal disease beneficiary only</li> <li>• Deemed insured (hospital insurance only)</li> </ul>
TA	Medicare Qualified Government Employment (MQGE) primary beneficiary
TB	MQGE aged spouse (1st claimant)
TC	MQGE childhood disability benefits (CDB) (1st claimant)
TD	MQGE aged widow(er) (1st claimant)
TE	MQGE young widow(er) (1st claimant)
TF	MQGE parent (male)
TG	MQGE aged spouse (2nd claimant)
TH	MQGE aged spouse (3rd claimant)

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**MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION**

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TJ	MQGE aged spouse (4th claimant)
TK	MQGE aged spouse (5th claimant)
TL	MQGE aged widow(er) (2nd claimant)
TM	MQGE aged widow(er) (3rd claimant)
TN	MQGE aged widow(er) (4th claimant)
TP	MQGE aged widow(er) (5th claimant)
TQ	MQGE parent (female)
TR	MQGE young widow(er) (2nd claimant)
TS	MQGE young widow(er) (3rd claimant)
TT	MQGE young widow(er) (4th claimant)
TU	MQGE young widow(er) (5th claimant)
TV	MQGE disabled widow(er) (5th claimant)
TW	MQGE disabled widow(er) (1st claimant)
TX	MQGE disabled widow(er) (2nd claimant)
TY	MQGE disabled widow(er) (3rd claimant)
TZ	MQGE disabled widow(er) (4th claimant)
Range T2 Thru T9	MQGE (CDB) (2nd to 9th claimant)
W	Disabled widow, age 50 or over (1st claimant)
W1	Disabled widower, age 50 or over (1st claimant)
W2	Disabled widow (2nd claimant)
W3	Disabled widow(er) (2nd claimant)
W4	Disabled widow (3rd claimant)
W5	Disabled widower (3rd claimant)
W6	Disabled surviving divorced wife (1st claimant)
W7	Disabled surviving divorced wife (2nd claimant)
W8	Disabled surviving divorced wife (3rd claimant)
W9	Disabled widow (4th claimant)
WB	Disabled widower (4th claimant)
WC	Disabled surviving divorced wife (4th claimant)
WF	Disabled widow (5th claimant)
WG	Disabled widower (5th claimant)
WJ	Disabled surviving divorced (5th claimant)
WR	Disabled surviving divorced husband (1st claimant)
WT	Disabled surviving divorced husband (2nd claimant)

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**MEDI-CAL ELIGIBILITY MANUAL - PROCEDURES SECTION**

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**TABLE OF RAILROAD RETIREMENT BOARD PREFIXES AND EQUIVALENT  
SSA BENEFICIARY IDENTIFICATION CODES (BICs)**

<u>RRB Claim Prefix</u>	<u>SSA Bic</u>	<u>Type RRB Beneficiary</u>
A	10	Retirement—employee or annuitant
H	80	RR pensioner (age or disability)
MA	14	Spouse of RR employee or annuitant (husband or wife)
MH	84	Spouse of RR pensioner
WCD*	43	Child of RR employee
WCA*	13	Child of RR annuitant
CA	17	Disabled adult child of RR annuitant
WD	46	Widow or widower of an RR employee
WA	16	Widow or widower of an RR annuitant
WH	86	Widow or widower of an RR pensioner
WCD*	43	Widow of employee with a child in her care
WCA*	13	Widow of annuitant with a child in her care
WCH	83	Widow of pensioner with a child in her care
PD	45	Parent of RR employee
PA	15	Parent of RR annuitant
PH	85	Parent of RR pensioner
JA	11	Survivor joint annuitant (an annuitant who has taken a reduced amount to guarantee payment to a surviving spouse)

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\*WCD and WCA have two designations each.

Railroad Retirement Board numbers are either six or nine digit letters. For reporting purposes, the second and third position of the RR number must contain a letter or be left blank, i.e.:

A	706306
MA	706306
WCA	706306



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## MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

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### 15H-HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

This section provides background information and procedures pertaining to the Health Insurance Premium Payment (HIPP) and Employer Group Health Plan (EGHP) Programs.

#### 1. Program Background

The HIPP Program (Welfare and Institutions Code, Section 14124.91) was established by enactment of Assembly Bill 3328 (Margolin, Chapter 940, Statutes of 1986). This law authorizes the Department of Health Services (DHS), whenever it is cost effective, to pay health coverage premiums on behalf of Medi-Cal beneficiaries. Cost effectiveness is defined by Section 50778, California Code of Regulations (CCR) as when the annual cost of the premium is less than half the estimated cost of Medi-Cal benefits. The primary objective of the Program is to continue a high-cost Medi-Cal beneficiary's other health coverage by paying medical coverage premiums for the beneficiary. Paying premiums for high-cost medical results in a reduction of Medi-Cal costs.

The EGHP Program (Section 4402, Omnibus Budget Reconciliation Act of 1990 (OBRA '90)) mandates (effective January 1, 1991), that all states, when it is cost effective, pay the health insurance premiums, deductibles, co-payment and other cost-sharing obligations for Medi-Cal recipients eligible for enrollment in an employer group health plan. The State may also pay the premiums (but not other cost-sharing obligations) for a non-Medi-Cal eligible if the Medi-Cal eligible's enrollment in the health plan is dependent on the non-Medi-Cal eligible's enrollment. In addition, OBRA '90 mandates that when it is cost effective, enrollment in an employer or group health plan is a condition of Medicaid eligibility except for an individual (such as a child) who is unable to enroll on his/her own behalf.

To participate in the HIPP and EGHP Programs, applicants will have to prove that their monthly medical costs are at least twice as much as the monthly insurance premiums.

#### 2. HIPP/EGHP Qualifying Criteria

- a. The applicant must currently be on Medi-Cal.
- b. The Medi-Cal Share of Cost, if any, must be \$200 or less.
- c. There is a expensive medical condition. The average monthly savings to Medi-Cal from the health insurance must be at least twice the monthly insurance premiums. The monthly Share of Cost will be subtracted from the monthly health care costs to determine if paying the premiums is cost effective.
- d. There is a current health insurance policy, COBRA continuation policy, or a COBRA conversion policy in effect, or an employer group health plan for which enrollment application has not been made, but which is available to the beneficiary.
- e. The application must be completed and returned in time for the State to process the application and pay the premium.
- f. The health insurance policy must cover the high cost medical condition.

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- g. The policy must not be issued through the California Major Risk Medical Insurance Board (MRMIB).
- h. There is no enrollment in a Medi-Cal related prepaid health plan, County Health Initiative, Geographic Managed Care, or the County Medical Services Program (CMSP).
- i. The premiums are not the responsibility of an absent parent.

### 3. County Responsibilities

In order to identify Medi-Cal applicants/beneficiaries who are potentially eligible for the HIPP/EGHP Programs, county workers must:

- a. Issue a Health Insurance Questionnaire (DHS 6155—Revised 10/90) form to the beneficiary to complete during the application and redetermination processes when the applicant/beneficiary indicates: 1) that he/she or a family member is employed and that employer-related health insurance is available but has not been applied for, 2) that he/she or a family member currently has individual, group or employer-related health insurance and has a high cost medical condition.
  - (1) If the applicant/beneficiary currently has health insurance (private or employer related) AND a high cost medical condition.
    - (a) Complete the DHS 6155. Indicate the illness and the name of the applicant/beneficiary with the illness in the #9 area of the form. In the upper right hand corner of the DHS 6155 form, write the notation "HIPP".
  - (2) If the applicant/beneficiary is not covered by a health plan, but has a high cost medical condition, AND health insurance is available through an employer (or family member's employer), but the applicant/beneficiary has not enrolled:
    - (a) Complete the DHS 6155. Indicate the illness, and the name of the applicant/beneficiary with the illness in the #9 area of the form. Also, indicate the name(s) and Social Security Number(s) of beneficiaries who could be enrolled, the name/address of the employer, the name of the available health insurance, and the name and Social Security Number of the employee who has the insurance available to him/her. Check the #6 box "Medical coverage available through employer, but has not been applied for". In the upper right hand corner of the DHS 6155 form, write the notation "EGHP REFERRAL ONLY". This indicates that the applicant(s)/beneficiary(s) listed do not currently have the insurance and you are completing an EGHP referral so that DHS can determine if it would be cost effective to purchase the employer-related health insurance for the applicant/beneficiary with a high cost medical condition.

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- (3) If insurance is available through an employer (or family member's employer), but has not been enrolled in and no one in the case has a high cost medical condition.
- (a) Complete the DHS 6155. Indicate the name(s) and Social Security Number(s) of beneficiaries who could be enrolled, the name/address of the employer, the name of the available health insurance, and the name and Social Security Number of the employee who has the insurance available to him/her. Check the #6 box "Medical coverage available through employer, but has not been applied for." In the upper right hand corner of the DHS 6155 form, write the notation "EGHP REFERRAL ONLY". This indicates that the applicant(s)/beneficiary(s) listed do not currently have the insurance and you are completing an EGHP referral so that DHS can determine if it would be cost effective to purchase the employer-related health insurance.
- b. Assure that critical segments of the DHS 6155 (applicant/beneficiary name, Medi-Cal identification number, applicant/beneficiary telephone number, insurance carrier name, union/employer name and telephone number) are complete, accurate, and readable.
- SPECIAL NOTE:** If the beneficiary cannot be given the form in person and the beneficiary notifies the CWD that his/her health insurance has or is about to terminate, or the beneficiary has not applied for employer-related health insurance, the Eligibility Worker (EW) must send the Health Insurance Questionnaire (DHS 6155) form to the beneficiary to complete, sign, and date. Instructions must be given to the beneficiary to mail the form to the DHS.
- c. Advise the applicant/beneficiary that providing the health insurance information will not interfere with Medi-Cal Eligibility, but if payment for the group or employer-related health insurance plan is approved by the Department, enrollment in the health plan is mandatory. Disenrollment from the plan by the applicant/beneficiary, without the approval of Department of Health Services, is cause for discontinuance of Medi-Cal eligibility.
- d. Advise the applicant/beneficiary that if health insurance coverage is available from any source, (i.e., employer, union), at no cost to the beneficiary, the applicant/beneficiary must enroll. If the applicant/beneficiary fails to cooperate by not enrolling in the plan, the county worker must deny or discontinue Medi-Cal eligibility.
- e. Retain a copy of the Health Insurance Questionnaire (DHS 6155) in the case file.
- f. Mail the completed Health Questionnaire (DHS 6155) within five (5) days to the Department of Health Services. Send the HIPP or EGHP DHS 6155 application form in a separate envelope from all other DHS 6155 forms to:

Department of Health Services  
Medi-Cal Third Party Liability Branch  
HIPP Unit  
MS 4719  
P.O. Box 997422  
Sacramento, CA 95899-7422

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- g. Notify the Department immediately by calling (866) 298-8443 if the County determines that a beneficiary has withdrawn from enrollment in a plan for which DHS pays premiums under HIPP or EGHP. The Department will direct the County by letter to discontinue Medi-Cal eligibility upon verification of the beneficiary's disenrollment from the plan. The County must notify the beneficiary that eligibility has been withdrawn in accordance with Section 50179(c)(7), Title 22, CCR, when instructed by the Department to discontinue Medi-Cal eligibility.
- h. Review and recompute the beneficiary's Share of Cost as necessary in accordance with Articles 12A and 12B (Share of Cost) of the procedures portion of the Medi-Cal Eligibility Manual.

#### 4. Department of Health Services Responsibilities

Utilizing the HIPP/EGHP qualifying criteria the Department shall:

- a. Review the Health Insurance Questionnaire (DHS 6155), contact applicant/beneficiary for additional documentation and approve the application when it is determined to be cost effective for the State to pay the health insurance premiums.
- b. Notify the County and the beneficiary of State's intent to approve and/or terminate payment of the health insurance coverage.