STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
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CRAMENTO, CA 95814
(916) 445-1912

March 18, 1981

All County Welfare Directors
All County Data Processing Officers

Letter No. 81-13

IMPLEMENTATION OF NEW STATE STATUTE

AB 1263, which became law on January 1, 1981 added two special parenteral hyperalimentation programs to the currently existing Special Dialysis Programs. Pending filing of regulations, the programs are being implemented directly from the revised statutes: Welfare and Institutions Code, Sections 14142 and 14145. Counties are to accept and process applications for the programs, based on the procedures and instructions issued with this letter. Eligibility for the new programs is effective January 1, 1981. Clients may apply for the program retroactively back to January 1, until the regulations are effective. The regulations will contain a cutoff date for receipt of retroactive applications.

A. Program Description

Parenteral hyperalimentation, or total parenteral nutrition (TPN) as it is commonly called, provides total nutrient replacement through a catheter positioned in the chest for persons who, for various medical reasons, are unable to eat and digest food.

The statute provides that the State will pay part of the treatment costs for two categories of people who require TPN:

1. Those who are not eligible for regular Medi-Cal because of excess property. These persons will be designated as the "TPN-Only" category. (Welfare and Institutions Code, Section 14142.) TPN-Only eligibility is based on the current Dialysis-Only eligibility rules. The only differences are the underlying medical conditions covered and the reduced likelihood of a TPN client having Medicare coverage, since Medicare does not have any special TPN coverage provisions. Benefits will be limited to inpatient hospital care for TPN and related services, including home TPN training, as well as home TPN treatment. (The Legislature does not intend the term "related services" to include Medi-Cal coverage for treatment of the underlying condition which caused the need for TPN.)

2. Those who are eligible for regular Medi-Cal with a share of cost and who are employed. These persons will be designated as the "TPN Supplement" category. (Welfare and Institutions Code, Section 14145.) TPN-Supplement eligibility is based on the current Dialysis-Only eligibility rules, except for the medical condition involved and the Medicare coverage consideration. Services to the beneficiary will be limited to home TPN and related services only. Acute hospital care for TPN is not covered under the TPN Supplement program.

Persons in both categories are required by statute to utilize whatever other health coverage they may have before using Medi-Cal benefits. (This is true for the Special Dialysis Programs as well.)

In order to track special program eligibles and special program costs, the TPN Only group will be assigned aid code 73; the TPN Supplement group will be assigned aid code 74.

B. Changes to Existing Regulations

In most instances, reference to TPN treatment has simply been incorporated into the existing Special Dialysis Program regulations. However, there are four important changes:

1. Scope of benefits, or treatment, has been removed from the eligibility regulations since this topic is covered in Chapter 3 of Title 22, California Administrative Code. Specific limits on allowable treatment will be described in provider bulletins.

2. Transfer of property rules have been specifically identified as applying to the Special Programs.

3. Retroactive eligibility for Special (TPN) Programs is specifically prohibited.

4. An extended application period is provided for TPN applicants.

The draft regulations are to be used as guidelines only. Any denial notice of action must use the appropriate Welfare and Institutions Code citation.

C. Changes to Existing Procedures

Medi-Cal Eligibility Manual Procedures Sections have been amended as follows:

1. "17A Medi-Cal Special Treatment Programs" has been revised. A brief background and a summary of each program are provided. The county is instructed to use the Application for Public Assistance, Form CA 1, for applications for any of these programs. In addition, the county shall determine eligibility for the "Supplement" or the "Only" program if eligibility under the other program is terminated. All reference to scope of benefits is deleted.

2. "17B Medi-Cal Special Treatment Programs Identification Cards" has been expanded to include facsimilies of the TPN cards along with the card enclosures which accompany each card.

3. "17D Medi-Cal Dialysis Supplement Special Treatment Program: Client Information" is essentially unchanged except for a short explanation of what happens if a client loses regular Medi-Cal eligibility.

4. "17E Medi-Cal TPN Supplement Special Treatment Program: Client Information" is new. A copy of this information statement is to be provided to applicants who qualify for this program and a second copy is to be kept in the client case file. Since there are very few persons who will qualify for this program, the county should make photocopies as needed.

D. Changes to Existing Forms and Instructions

1. Medi-Cal Special Treatment Programs -- Percentage Obligation Computation, Form 176D. This form has been modified slightly to accommodate the new programs. Reference to specific treatment modalities has been removed. This form is available and may be ordered from the DHS warehouse following regular procedures. However, a small interim supply may be requested from your Medi-Cal program consultant.

   Instructions to Form 176D have been revised in response to county feedback on the prior instructions. Detailed examples are provided in certain areas.

2. Medi-Cal Special Treatment Programs -- Notice of Action, Form 239F has been revised slightly. Reference to a specific program has been removed. The county will identify the program for which application was made in the appropriate blank spaces.

   Existing Special Medi-Cal Dialysis forms may be used until a supply of the new forms is available, or the county may photocopy the forms which accompany this letter. Major counties with a potential for TPN program applicants will be sent a small supply of the new forms as soon as they are printed.

E. Provider Reimbursement

There will be some period of delay before Computer Sciences Corporation, (CSC) the Medi-Cal claims processor, can accept and pay claims for services provided to beneficiaries under these new aid codes. Newly approved applicants should be informed of this fact. Once CSC can accept these new aid codes, claims will be processed and paid retroactively to January, 1981.

F. Other

Copies of the draft regulations, procedures, and forms to be used in implementing these new programs are attached. The attached regulations are being filed on an emergency basis and will be issued to all holders of the

Medi-Cal Eligibility Manual after they are adopted and filed with the Secretary of State. Until regulations are filed, the county must cite the authority of Welfare and Institutions Code, Sections 14142 and 14145 on MC 239F notices of action denying or discontinuing TPN eligibility.

If you have any questions regarding implementation of this statute, please contact your Medi-Cal program consultant.

Sincerely,

Original signed by

Barbara V. Carr, Acting Chief
Medi-Cal Eligibility Branch

Attachments
cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Expiration Date: September 30, 1981

REPEAL

50261. Special Medi-Cal Dialysis Programs. (a) Special Medi-Cal Dialysis programs consist of:

(1) The Medi-Cal Dialysis Only program which covers persons who are eligible only for dialysis and related services.

(2) The Medi-Cal Dialysis Supplement program which covers persons eligible under the Medically Needy or the Medically Indigent programs and who also meet the specific eligibility requirements contained in Article 17.

Note: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code.

Reference: Sections 14140, 14141, 14142, 14143 and 14145, Welfare and Institutions Code.

PRELINED DRAFT PAPER INDICATES AND IS TO BE USED ONLY FOR ALL NEW REGULATORY LANGUAGE.

DRAFT – FOR DISCUSSION ONLY
Date

50264. Medi-Cal Special Treatment Programs. (a) Medi-Cal Special Treatment Programs consist of:

(1) The Medi-Cal Special Treatment Programs -- Only:

(A) The Medi-Cal Dialysis Only program which covers persons who are eligible under provisions of Article 17, only for dialysis and related services.

(B) The Medi-Cal Parenteral Hyperalimentation Only program which covers persons who are eligible under provisions of Article 17, only for parenteral hyperalimentation and related services.

(2) The Medi-Cal Special Treatment Programs -- Supplement:

(A) The Medi-Cal Dialysis Supplement program which covers persons eligible under the Medically Needy or the Medically Indigent programs and who also meet the applicable eligibility requirements contained in Article 17.

(B) The Medi-Cal Parenteral Hyperalimentation Supplement program which covers persons who are eligible under the Medically Needy or Medically Indigent programs and who also meet the applicable eligibility requirements contained in Article 17.

Note: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code.

Reference: Sections 14140, 14141, 14142, 14143, 14144 and 14145, Welfare and Institutions Code.

50801. Medi-Cal Special ~~Medi-Cal Dialysis~~ Treatment Programs -- General.

For the purposes of determining eligibility for ~~Special~~ Medi-Cal Special Treatment ~~Dialysis~~ Programs, the regulations in this article shall supersede any conflicting regulations in this chapter.

Note: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code.

Reference: Sections 14141, 14142, 14143, 14144, and 14145, Welfare and Institutions Code.

50803. Medi-Cal Special ~~Medi-Cal-Dialysis~~ Treatment Programs Beneficiary.

(a) Medi-Cal Special ~~Medi-Cal-Dialysis~~ Treatment Programs beneficiary means a person who is either a Medi-Cal ~~Dialysis~~ Special Treatment Programs -- Only, beneficiary or a Medi-Cal ~~Dialysis~~ Special Treatment Programs -- Supplement, beneficiary.

(1) Medi-Cal ~~Dialysis~~ Special Treatment Programs -- Only, beneficiary means a person who has been determined eligible for ~~the~~ Medi-Cal ~~Dialysis~~ Special Treatment Programs -- Only, ~~program~~ coverage in accordance with Section 50817 ~~(e)~~ (b).

(2) Medi-Cal ~~Dialysis~~ Special Treatment Programs -- Supplement, beneficiary means a person who is a Medi-Cal Medically Needy or Medically Indigent beneficiary and who has been determined eligible for the Medi-Cal ~~Dialysis~~ Special Treatment Programs -- Supplement, ~~program~~ coverage in accordance with Section 50817 ~~(d)~~ (c).

Note: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code.

Reference: Sections 14141, 14142, 14143, 14144, 14145, 14005.4 and 14005.7, Welfare and Institutions Code.

50805. Real Property — Medi-Cal Special ~~Medi-Cal Dialysis~~ Treatment Programs. Real property means any interest in land and improvements.

Note: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code.

Reference: Sections 14140, 14141, 14142, 14143, 14144 and 14145, Welfare and Institutions Code.

50807. Personal Property -- Medi-Cal Special ~~Medi-Cal Dialysis~~ Treatment Programs.

Personal property means cash, savings accounts, securities, and similar items; notes, mortgages, and deeds of trust; the cash surrender value of life insurance on the life of the beneficiary, spouse or any member of the family; motor vehicles; and any other property or equity other than real property.

Note: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code.

Reference: Sections 14140, 14141, 14142, 14143, 14144 and 14145, Welfare and Instututions Code.

50809. Gross Income -- Medi-Cal Special ~~Medi-Cal Dialysis~~ Treatment Programs. Gross income means adjusted annual gross income as used for purposes of federal income tax reporting.

Note: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code.

Reference: Sections 14140, 14141, 14142, 14143, 14144 and 14145, Welfare and Institutions Code.

50813. Percentage Obligation. Percentage obligation means the percent of the cost of dialysis or parenteral hyperalimentation and related services for which a Medi-Cal Special ~~Medi-Cal Dialysis~~ Treatment Programs beneficiary must either pay or assume full legal responsibility.

Note: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code.

Reference: Sections 14141, 14142, 14143, 14144 and 14145, Welfare and Institutions Code.

50815. Application Process -- ~~Special Medi-Cal Dialysis~~ Medi-Cal Special Treatment Programs.

~~(a) Applications for the Special Medi-Cal Dialysis~~ Medi-Cal Special Treatment ~~Programs shall be processed in accordance with Article 4.~~

(a) The county department shall receive and act on applications for the Medi-Cal Special Treatment Programs in accordance with Article 4.

(1) The Application for Public Social Services, Form CA 1, shall be used as the application form.

(2) The name of the applicable Medi-Cal Special Treatment Program shall be indicated immediately above the "Medi-Cal card" box on Form CA 1.

(b) The county, in addition to meeting the requirements of Section 50157 (f) and (g), shall provide Medi-Cal ~~Dialysis~~ Special Treatment Programs -- Supplement applicants a copy of the applicable Medi-Cal ~~Dialysis~~ Special Treatment Programs -- Supplement Client Information statement at the initial and redetermination or reapplication interviews. A signed and dated copy of the applicable Medi-Cal ~~Dialysis~~ Special Treatment Programs -- Supplement Client Information statement shall be placed in the case folder.

(c) A redetermination shall be required annually.

(d) The county department shall require Medi-Cal ~~Dialysis~~ Special Treatment Programs -- Only and Medi-Cal ~~Dialysis~~ Special Treatment Programs -- Supplement beneficiaries to complete a Medi-Cal Status Report Form MC 176S no later than the third month following the month of Medi-Cal Special ~~Dialysis~~ Treatment Programs eligibility approval and at three month intervals thereafter. Status reports shall not be required during the quarter in which an annual redetermination is completed.

(1) A reevaluation shall be made when a change in circumstances affects the percentage obligation or eligibility.

(2) Information supplied on the status report shall be considered in reevaluating percentage obligation or eligibility.

(e) Retroactive eligibility, as defined by Section 50710, shall not be provided under the ~~Special~~ Medi-Cal ~~Dialysis~~ Special Treatment Programs.

Note: Authority cited: Sections 10725, 14124.4, Welfare and Institutions Code.

Reference: Sections 14141, 14142, 14143, 14144 and 14145, 14005.4, 14005.7, Welfare and Institutions Code.

50817. Eligibility Requirements -- ~~Special~~ Medi-Cal ~~Dialysis~~ Special Treatment Programs. (a) Applicants for ~~Special~~ Medi-Cal ~~Dialysis~~ Special Treatment Programs shall meet cooperation, citizenship, residence, ~~and~~ institutional status and transfer of property requirements in Articles 4,6, ~~and~~ 7, and 9.

...

~~(b)--Applicants shall apply for Medicare within ten days of making application for a Special Medi-Cal Dialysis program.--Applicants who fail to apply for Medicare within the prescribed time period, except for good cause as defined under Section 50175(e), shall have the application denied under the Special Medi-Cal Dialysis programs.~~

~~(c)~~ (b) Applicants shall be eligible for ~~the~~ Medi-Cal ~~Dialysis~~ Special Treatment Programs -- Only ~~program~~ coverage if they are all of the following:

(1) In need of dialysis or parenteral hyperalimintation and related services. ~~as defined in Section 51157.~~

(2) Not eligible for Medi-Cal under any other program.

(3) Not eligible for Medicare if under 65 years of age. Medicare eligibility shall not affect Medi-Cal ~~Dialysis~~ Special Treatment Programs -- Only, eligibility for persons age 65 or over.

~~(d)~~ (c) Applicants shall be eligible for the Medi-Cal ~~Dialysis~~ Special Treatment Programs -- Supplement, ~~program~~ coverage if they are all of the following:

(1) Eligible under Section 50203 as Medically Needy or Section 50251 as Medically Indigent. Medicare eligibility shall not affect Medi-Cal ~~Dialysis~~ Special Treat-

ment Programs -- Supplement eligibility.

(2) In need of dialysis or parenteral hyperalimentation and related services. ~~as defined in Section 51157.~~

(3) Employed, or self-employed.

(4) Earning an individual gross income that exceeds the minimum maintenance need for one person.

(d) Applicants for the Medi-Cal Special Treatment Programs shall apply for Medicare as follows:

(1) Applicants for dialysis coverage shall apply for Medicare within ten days of making application for a Medi-Cal Special Treatment Program. Applicants who fail to apply for Medicare within the prescribed time period, except for good cause as exemplified under Section 50175 (c), shall have the application denied under that specific Medi-Cal Special Treatment Program.

(2) Applicants for or beneficiaries of parenteral hyperalimentation coverage shall apply for Medicare in accordance with Section 50777.

Note: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code.

Reference: Sections 14005.4, 14005.7, 14015, 14141, 14142, 14143, 14144 and 14145, Welfare and Institutions Code.

50819. Verification Requirements -- ~~Special Medi-Cal Dialysis~~ Medi-Cal Special Treatment Programs. (a) All ~~Special Medi-Cal Dialysis~~ Medi-Cal Special Treatment Program applicants or beneficiaries shall provide the following:

(1) Applicable verification required under Article 4.

(2) A copy of the Social Security statement of Medicare status to the county department within ten days of receipt.

(b) Dialysis Program beneficiaries shall provide ~~(3)~~ verification of Medicare status at the following times:

~~(A)~~ (1) Annual redetermination, if previous verification does not indicate current status.

~~(B)~~ (2) Each month in which it appears there may be a change in Medicare eligibility status if the beneficiary is currently ineligible for Medicare.

Note: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code.

Reference: Sections 14141, 14142, 14143, 14144 and 14145, Welfare and Institutions Code.

50820. Eligibility Determination for ~~Special~~ Medi-Cal ~~Dialysis~~ Special Treatment Programs. (a) The county department shall determine a person's eligibility for the ~~Special~~ Medi-Cal Special Treatment ~~Dialysis~~ programs as follows:

(1) Persons who apply for the Medi-Cal Dialysis Only Program or the Medi-Cal Dialysis Supplement Program shall hav their eligibility determined as of the month of application.

(2) Persons who apply for the Medi-Cal Parenteral Hyperalimentation Only Program or the Medi-Cal Parenteral Hyperalimentation ~~Dialysis~~ Supplement Program on or before ~~June 30, 1980~~ May 31, 1981 shall have their eligibility determined retroactively to January 1, ~~1980~~ 1981, for months in which they ~~were eligible as Medically Needy or Medically Indigent.~~ otherwise meet program eligibility requirements.

(3) Persons who apply for the Medi-Cal ~~Dialysis~~ Parenteral Hyperalimentation Only Program or the Medi-Cal Parenteral Hyperalimentation Supplement Program after ~~June 30, 1980~~ May 31, 1981 shall have their eligibility determined as of the month of application.

Note: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code.

Reference: Section 14142 and 14145, Welfare and Institutions Code.

50821. ~~Special Medi-Cal Dialysis~~ Medi-Cal Special Treatment Programs Cards.

(a) The Department shall provide a ~~Special Medi-Cal Dialysis~~ Medi-Cal Special Treatment Program card to each ~~Special Medi-Cal Dialysis~~ Medi-Cal Special Treatment Programs beneficiary. Each Medi-Cal Special Treatment Program card shall identify the program for which the beneficiary is eligible.

~~(b) The Medi-Cal Dialysis Only or Medi-Cal Dialysis Supplement card shall be written authorization that the person named is entitled to Medi-Cal Dialysis Only or Medi-Cal Dialysis Supplement program coverage subject to the conditions of (c) and (d).~~

(b) The individual Medi-Cal Special Treatment Programs cards shall be authorization for payment of the cost of covered services in accordance with regulations of the Department, if the costs of those services:

(1) Were incurred during the period covered by the Medi-Cal ~~Dialysis Only or Medi-Cal Dialysis Supplement~~ Special Treatment Programs card.

(2) Are not payable by a third party under contractual or other legal entitlement.

(3) Are not paid or obligated by the Medi-Cal ~~Dialysis Only or Medi-Cal Dialysis Supplement~~ Special Treatment Programs beneficiary as part of the percentage obligation.

~~(c) The Medi-Cal Dialysis Only or Medi-Cal Dialysis Supplement cards shall be authorization for payment in accordance with regulations of the Department for dialysis and related services, as described in Section 51157, except for Section (d), below, if the costs of these services:~~

~~(d) The Medi-Cal Dialysis Supplement card shall not be authorization for routine full care dialysis treatment. This exclusion shall not preclude provision of full care dialysis treatment in case of a certified medical emergency.~~

Note: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code.

Reference: Sections 14141, 14142, 14143, 14144 and 14145, Welfare and Institutions Code.

50827. Determination and Application of Percentage Obligation -- ~~Special~~ Medi-Cal ~~Dialysis~~ Special Treatment Programs. (a) The percentage obligation shall be based upon the annual net worth of the Medi-Cal ~~Dialysis-Only-or Medi-Cal-Dialysis-Supplement~~ Special Treatment Programs applicant or beneficiary.

(b) The percentage obligation shall be applied to the cost of allowable ~~dialysis-and-related~~ services remaining unpaid, after the Medi-Cal ~~Dialysis Only-or-Dialysis-Supplement~~ Special Treatment Programs beneficiary has utilized benefits available under any other federal or state law or other contractual or legal entitlements.

(c) The amount of the percentage obligation shall not be:

(1) A claim against any of the Medi-Cal ~~Dialysis-Only-or-Dialysis-Supplement~~ Special Treatment Programs.

(2) Reimbursed by a third party.

(d) The percentage obligation of a Medi-Cal ~~Dialysis~~ Special Treatment Programs -- Only beneficiary shall be determined as follows:

(1) Applicants or beneficiaries who are determined to have an annual net worth of $5,000 or more shall be assigned a percentage obligation of two percent for each $5,000 of net worth, including the first $5,000.

(e) The percentage obligation of a Medi-Cal ~~Dialysis~~ Special Treatment Programs -- Supplement, beneficiary shall be determined as follows:

(1) Applicants or beneficiaries who are determined to have an annual net worth of less than $5,000 shall be assigned a zero percentage obligation.

(2) Applicants or beneficiaries who are determined to have an annual net worth of $5,000 or more shall be assigned a percentage obligation of one percent for each $5,000 of net worth, including the first $5,000.

Note: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code.

Reference: Sections 14141, 14142, 14143, 14144 and 14145, Welfare and Institutions Code.

50831. Share of Cost -- Medi-Cal ~~Dialysis~~ Special Treatment Programs -- Supplement, Beneficiary. (a) Services within the Medi-Cal scope of benefits, other than ~~treatment for dialysis and related services as described in Section 51157~~ services covered under the Medi-Cal Special Treatment Programs -- Supplement, shall be subject to a share of cost.

~~(b) Routine full care dialysis treatment shall be subject to a share of cost.~~

~~(c)~~ (b) Share of cost shall be determined in accordance with Section 50653.

~~(d)~~ (c) Costs which are paid or obligated by the beneficiary under the Medi-Cal ~~Dialysis~~ Special Treatment Programs -- Supplement, ~~program~~ in any one month shall be applied to the share of cost for that month.

~~(e)~~ (d) A Medi-Cal ~~Dialysis~~ Special Treatment Programs -- Supplement beneficiary, who is a member of an MFBU which has met its share of cost, shall be certified as eligible for Medi-Cal services and shall be issued a Medi-Cal card in accordance with Section 50658. Once certified for full Medi-Cal coverage, all Medi-Cal services received by a beneficiary during that month shall be covered under the provisions of the full Medi-Cal program rather than under the provisions of the Medi-Cal ~~Dialysis~~ Special Treatment Programs -- Supplement ~~program~~.

Note: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code.

Reference: Sections 14005.4, 14005.7, 14005.9, 14005.4 and 14145, Welfare and Institutions Code.

5C - MEDI-CAL AID CODES

The following aid codes shall be used in the classification and reporting of Medi-Cal beneficiaries. Each aid code is identified as to the availability of federal financial participation (FFP):

1. Cash Grant

01 RCA/IR.....Refugee Cash Assistance -- Indochinese (FFP)

07 RCA-Other.....Refugee Cash Assistance -- Other (FFP)

08 ECA.....Cuban/Haitian Entrant Cash Assistance (FFP)

10 Aged.....Aid to the Aged (FFP)

20 Blind.....Aid to the Blind (FFP)

30 AFDC-FG.....Aid to Families with Dependent Children -- Family Group (FFP)

32 AFDC-FG (MM).....Aid to Families with Dependent Children -- Family Group (money management) (FFP)

33 AFDC-U (MM).....Aid to Families with Dependent Children -- Unemployed Parent (money management) (FFP)

35 AFDC-U.....Aid to Families with Dependent Children -- Unemployed Parent (FFP)

38 AFDC-CNST.....Aid to Families with Dependent Children -- Children Not in School or Training and Not Receiving Grant (FFP)

39 Four Mo. Cont. (Optional).....Four Month Continuing Eligibility -- Discontinued from cash grant due to increased earnings or increased hours of employment. (FFP)

Note: Prior to April 1978, all persons in this category were identified by aid code 30 in combination with pre/post indicator of "2".

40 AFDC-BHI.....Aid to Families with Dependent Children -- Foster Care (Boarding Homes and Institutions) (FFP)

42 AFDC-BHI-FED.....Aid to Families with Dependent Children -- Foster Care (Boarding Homes and Institutions) -- Federal Participation (optional aid code) (FFP)

50 APSB.....Aid to Potentially Self-Supporting Blind (non-FFP)

60 Disabled.....Aid to the Disabled (FFP)

2. 20% Social Security Increase

*16 Aged-20% SS.....Aid to the Aged -- 20% Disregard (FFP)

*26 Blind-20% SS.....Aid to the Blind -- 20% Disregard (FFP)

36 AFDC-20% SS.....Aid to Families with Dependent Children -- 20% Disregard (FFP)

46 AFDC-BHI-20% SS.....Aid to Families with Dependent Children -- Boarding Homes and Institutions -- 20% Disregard (FFP)

56 APSB-20% SS.....Aid to Potentially Self-Supporting Blind -- 20% Disregard (non-FFP)

*66 Disabled-20% SS.....Aid to the Disabled -- 20% Disregard (FFP)

3. In-Home Supportive Services

18 Aged-IHSS.....Aid to the Aged -- In-Home Supportive Services (FFP)

28 Blind-IHSS.....Aid to the Blind -- In-Home Supportive Services (FFP)

58 APSB-IHSS.....Aid to the Potentially Self-Supporting Blind -- In-Home Supportive Services (non-FFP)

68 Disabled-IHSS.....Aid to the Disabled -- In-Home Supportive Services (FFP)

* Note: These aid codes should also be used to designate persons determined eligible as Title II Disregard persons. See California Administrative Code, Title 22, Sections 50564 and 50660.

4. Medically Needy, No Share of Cost

14 Aged-MN.....Aid to the Aged -- Medically Needy, No Share of Cost (FFP)

24 Blind-MN.....Aid to the Blind -- Medically Needy, No Share of Cost (FFP)

34 AFDC-MN.....Aid to Families with Dependent Children -- Medically Needy, No Share of Cost (FFP)

44 AFDC-BHI-MN.....Aid to Families with Dependent Children -- Foster Care (Boarding Homes and Institutions) -- Medically Needy, No Share of Cost (FFP)

64 Disabled-MN.....Aid to Disabled -- Medically Needy, No Share of Cost (FFP)

65 Disabled-SGA.....Aid to Disabled -- Substantial Gainful Activity (non-FFP)

5. Medically Needy, Share of Cost

17 Aged-MN.....Aid to the Aged -- Medically Needy, Share of Cost (FFP)

27 Blind-MN.....Aid to the Blind -- Medically Needy, Share of Cost (FFP)

37 AFDC-MN.....Aid to Families with Dependent Children -- Medically Needy, Share of Cost (FFP)

47 AFDC-BHI-MN.....Aid to Families with Dependent Children -- Foster Care (Boarding Homes and Institutions) -- Medically Needy, Share of Cost (FFP)

65 Disabled-SGA.....Aid to Disabled -- Substantial Gainful Activity (non-FFP)

67 Disabled-MN.....Aid to the Disabled -- Medically Needy, Share of Cost (FFP)

6. Medically Needy Long-Term Care*

13 Aged-LTC.....Aid to the Aged -- Long-Term Care Status (FFP)

23 Blind-LTC.....Aid to the Blind -- Long-Term Care Status (FFP)

63 Disabled-LTC.....Aid to the Disabled -- Long-Term Care Status (FFP)

7. Medically Indigent

04 Aid for Adoption of Children Program (FFP)

45 Children in Foster Care (Under 21) Supported in Whole or in Part by Public Funds (FFP)

82 Medically Indigent, Under 21 -- No Share of Cost (FFP)

83 Medically Indigent, Under 21 -- Share of Cost (FFP)

84 Medically Indigent, Age 21 or Over -- No Share of Cost (non-FFP)

85 Medically Indigent, Age 21 or Over -- Share of Cost (non-FFP)

88 Medically Indigent, Age 21 or Over, Application Pending as Blind or Disabled -- No Share of Cost (non-FFP)

89 Medically Indigent, Age 21 or Over, Application Pending as Blind or Disabled -- Share of Cost (non-FFP)

8. Medi-Cal Special Treatment Programs

71 Medi-Cal Dialysis Only Program (non-FFP)

72 Medi-Cal Dialysis Supplement Program (non-FFP)

73 Medi-Cal TPN Only Program (non-FFP)

74 Medi-Cal TPN Supplement Program (non-FFP)

*Note: These aid categories should be used for all individuals whose eligibility is determined in accordance with Section 50605 regardless of whether there is share of cost involvement.

17A - MEDI-CAL SPECIAL TREATMENT PROGRAMS

I. Background

A. Over the past several years, the State Legislature has passed laws which provide limited Medi-Cal coverage to persons who need special types of life sustaining medical treatment.

Assembly Bill 3970, Montoya (Chapter 1531, Statues of 1974), provided persons ineligible for Medicare and regular Medi-Cal with special Medi-Cal Dialysis coverage. Such individuals have to pay a percentage of their treatment costs, based on their net worth.

Assembly Bill 275, Rosenthal (Chapter 1197, Statutes of 1979), allowed working dialysis patients, who were also eligible for regular Medi-Cal with a share of cost, to use the more liberal provisions of Assembly Bill 3970 in defining their share of the cost of their dialysis treatment.

Senate Bill 1263, Montoya (Chapter 102, Statutes of 1980), provides that persons who need parenteral hyperalimentation treatment (also known as total parenteral nutrition or TPN) shall be allowed the same type of limited Medi-Cal coverage as persons needing dialysis. TPN provides total nutrient replacement through a catheter positioned in the chest for persons who, for whatever reason, are unable to eat and digest food.

B. Special Treatment Programs -- Only, Group

Persons who need dialysis treatment or TPN treatment, who are not eligible for regular Medi-Cal because of excess property, may be eligible for limited Medi-Cal Special Treatment Programs coverage.

The Special Treatment -- Only, group is subdivided into two categories, each with its own unique aid code.

1. Dialysis Only -- aid code 71.

2. TPN Only -- aid code 73.

C. Special Treatment Programs -- Supplement, Group

Persons who need dialysis treatment or TPN treatment and who are eligible for regular Medi-Cal may also be eligible for limited Medi-Cal Special Treatment Programs coverage.

The Special Treatment -- Supplement, group is also subdivided into two categories, each with its own unique aid code.

1. Dialysis Supplement -- aid code 72.

2. TPN Supplement -- aid code 74.

Supplement beneficiaries who meet their regular Medi-Cal share of cost in a month will receive a regular Medi-Cal card. They must use this card for all services they receive after that point, including TPN or dialysis.

D. Funding

The Federal Government does not share in the Medi-Cal costs of the Special Treatment -- Only, beneficiaries. There is federal sharing in the costs of Special Treatment -- Supplement, beneficiaries, if those beneficiaries also meet their regular Medi-Cal share of cost in a month.

E. Beneficiary Portion of Special Treatment Program Costs

Special Treatment Program beneficiaries must pay a percent of the cost of each dialysis or TPN service. The percent is based on their annual net worth -- a combination of property and annual gross income (some property is exempt). The "percentage obligation" that these beneficiaries must pay is shown on their Medi-Cal Special Treatment Program card. The provider uses that percent figure to calculate what the beneficiary owes on each service. Patients who are Special Treatment Program -- Supplement, beneficiaries are also entitled to use that amount toward meeting the regular Medi-Cal share of cost.

F. Other Health Coverage and the Billing Process

If the patient has Medicare, private health insurance, or any other non-Medi-Cal coverage, that coverage must be billed first for the cost of a TPN or dialysis service. The patient percentage obligation applies to the balance remaining after payment by such other coverage. For example, if Medicare covers $80 of a $100 charge, the patient's percentage obligation will be applied only to the remaining $20. The provider subtracts what the beneficiary owes from the $20 and bills Medi-Cal for the rest.

II. Eligibility Procedures and Requirements

A. Eligibility Determination and Card Issuance

Individuals who wish to apply for one of the Medi-Cal Special Treatment Programs must go to their county welfare department and fill out an Application for Public Assistance, Form CA 1. The county worker shall write in the name of the program for which the person is applying immediately above the "Medi-Cal Card" block on the Form CA 1.

The county welfare department then determines the applicant's eligibility for a Medi-Cal Special Treatment Program based on program eligibility requirements. Once eligibility is established, the State Department of Health Services issues the applicable Medi-Cal Special Treatment Program card.

B. Medicare Application Requirement

All applicants for a Dialysis Special Treatment Program must apply for Medicare coverage within ten days of applying for one of the Dialysis Special Treatment Programs; they must also supply the county welfare department with a copy of the Social Security statement of Medicare status within ten days of their receipt of the statement.

Applicants for TPN Special Treatment Programs coverage must follow the normal requirements of regulation Section 50777 in applying for Medicare, since there is no special Medicare program for this group.

C. Medi-Cal Special Treatment Programs -- Only, Eligibility Requirements

To be eligible under these programs, a person must be all of the following in a month:

- In need of dialysis or TPN and related services.
- Not eligible for regular Medi-Cal because of excess property.
- Not currently eligible for Medicare if under age 65.
- Meet standard citizenship, cooperation, residence, institutional status, and transfer of property requirements for Medi-Cal.

Note: If a Medi-Cal Special Treatment Programs -- Only, beneficiary loses such program eligibility because he/she becomes eligible for regular Medi-Cal, eligibility must also be determined under Medi-Cal Special Treatment Programs -- Supplement.

D. Medi-Cal Special Treatment Programs -- Supplement, Eligibility Requirements

To be eligible under these programs, a person must be all of the following in a month:

- Eligible under the Medi-Cal medically needy or medically indigent program.

- In need of, and receiving, TPN or dialysis and related services.
- Employed or self-employed.
- Earning individually a gross income that exceeds the Medi-Cal minimum maintenance need for one person.
- Medicare eligibility does not affect Special Treatment Programs -- Supplement, eligibility.

Note: If a Medi-Cal Special Treatment Programs -- Supplement, beneficiary loses such program eligibility because of excess resources, eligibility must also be determined under Medi-Cal Special Treatment Programs -- Only.

17B - MEDI-CAL SPECIAL TREATMENT PROGRAMS IDENTIFICATION CARDS

I. Dialysis Special Treatment Programs

A. Dialysis Only Card -- Aid Code 71

Persons eligible under the Dialysis Only program will receive a RED "Limited Service Status" Medi-Cal card. The words "Dialysis Only" will appear on the address side of the card.

B. Dialysis Supplement Card -- Aid Code 72

Persons eligible under the Dialysis Supplement program will receive a RED "Limited Service Status" Medi-Cal card. The words "Dialysis Supplement" will appear on the address side of the card.

II. TPN Special Treatment Programs

A. TPN Only Card -- Aid Code 73

Persons eligible under the TPN Only program will receive a RED "Limited Service Status" Medi-Cal card. The words "TPN Only" will appear on the address side of the card.

B. TPN Supplement Card -- Aid Code 74

Persons eligible under the TPN Supplement program will receive a RED "Limited Service Status" Medi-Cal card. The words "TPN Supplement" will appear on the address side of the card.

Counties shall not issue MC 301 Medi-Cal cards to Medi-Cal Special Treatment Programs beneficiaries.

III. County Processing for Special Treatment Programs Card Issuance

When eligibility for one of the four Medi-Cal Special Treatment Programs has been established, the county shall forward the original of the MC 176-D to:

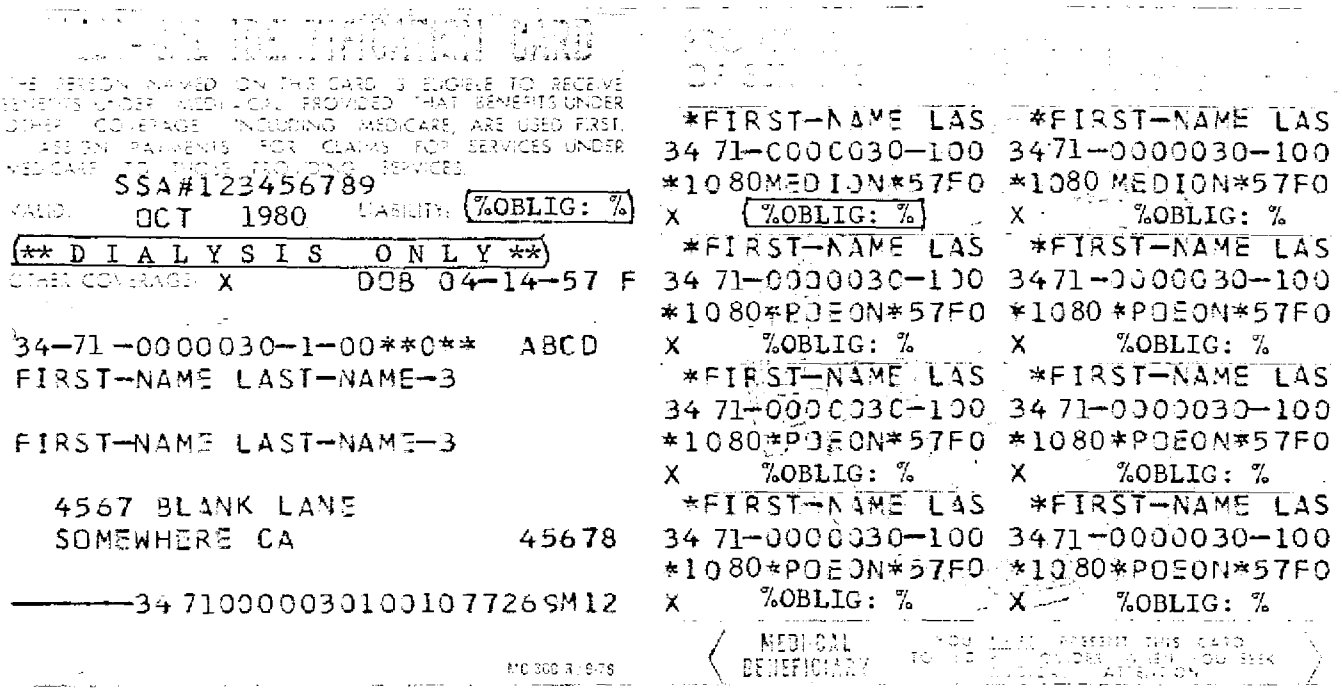
Department of Health Services
Benefits Review Unit
Att: Medi-Cal Special
Programs Coordinator
P. O. Box 668
Sacramento, CA 95803

The MC 176-D will be used to generate the appropriate Medi-Cal Special Treatment Program cards for the beginning month of eligibility and each month following, through the month of redetermination.

A new MC 176-D must be forwarded to Benefits Review Unit to generate cards beginning with the month after the month of redetermination and each month following, through the month of the next redetermination.

DIALYSIS ONLY STATEMENT

PERCENTAGE OBLIGATION



DIALYSIS AID CODE 71

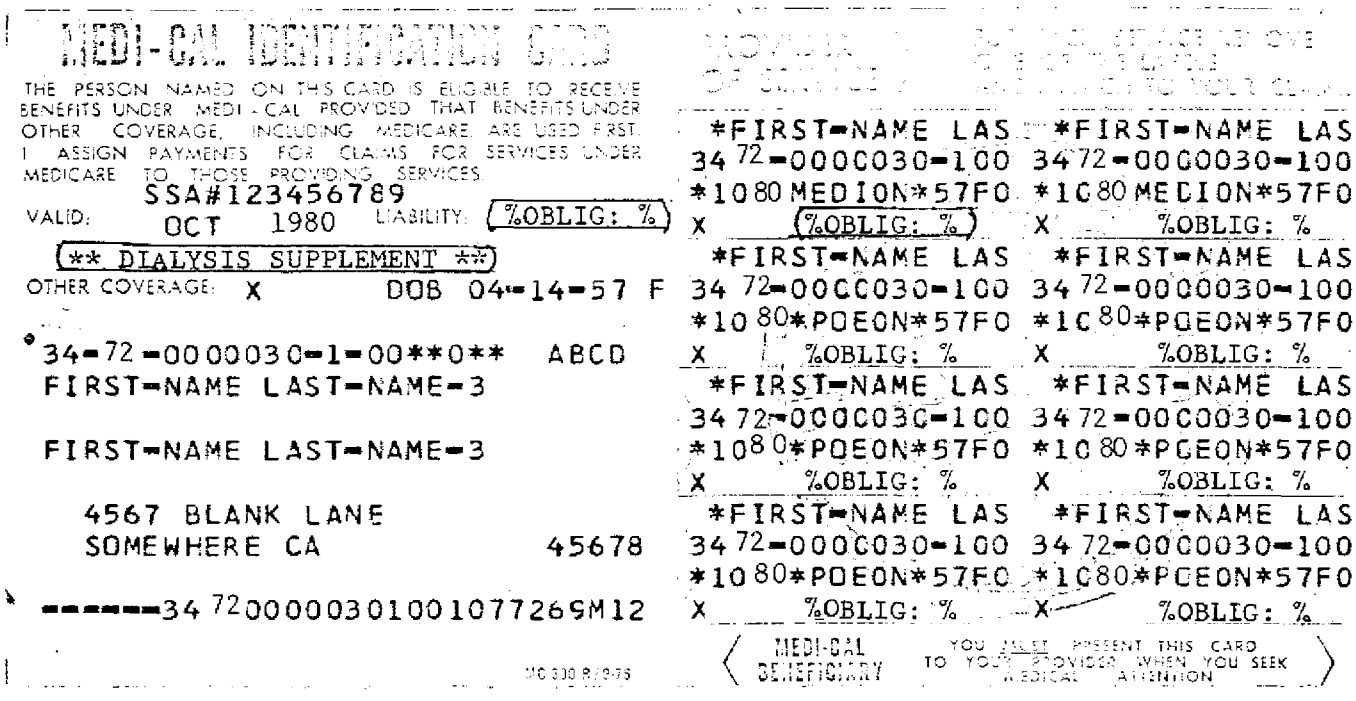
IV. Medi-Cal Dialysis Only Identification Card Enclosure

"The attached Medi-Cal identification card identifies you as eligible to receive benefits under the Medi-Cal Dialysis Only program. This identification card is to be presented to your provider when you seek dialysis services including related hospital and physician services associated with the treatment of renal failure, stabilization of renal failure, treatment of complications of dialysis and dialysis related laboratory tests, medical supplies, and drugs. Your Medi-Cal card may not be used for medical services which are not related to dialysis.

"Under the Medi-Cal Dialysis Only program you are obligated to pay a percentage of the costs of dialysis services not covered by other insurance or other government programs. Your percentage obligation is printed on your Medi-Cal card (%OBLIG:X%). Using this percentage your provider will compute the amount you must pay him for your dialysis services. For instance, if a dialysis service costs $1,000 and you have insurance or other coverage for $200, your percentage obligation would apply to the remaining $800. If your percentage obligation is 2 percent, then you must pay 2 percent of $800 or $16.00. The Medi-Cal program will then pay the remainder of reasonable charges."

DIALYSIS SUPPLEMENT STATEMENT

PERCENTAGE OBLIGATION


MEDI-CAL IDENTIFICATION CARD

THE PERSON NAMED ON THIS CARD IS ELIGIBLE TO RECEIVE BENEFITS UNDER MEDI-CAL PROVIDED THAT BENEFITS UNDER OTHER COVERAGE, INCLUDING MEDICARE, ARE USED FIRST. I ASSIGN PAYMENTS FOR CLAIMS FOR SERVICES UNDER MEDICARE TO THOSE PROVIDING SERVICES.

SSA#123456789

VALID: OCT 1980 LIABILITY: (%OBLIG: %)

(** DIALYSIS SUPPLEMENT **)

OTHER COVERAGE: X DOB 04-14-57 F

34-72-0000030-1-00**0** ABCD
FIRST-NAME LAST-NAME-3

FIRST-NAME LAST-NAME-3

4567 BLANK LANE
SOMEWHERE CA 45678

------34 72000003010010772695M12

MC 300 R/9-75

*FIRST-NAME LAS *FIRST-NAME LAS
34 72-0000030-100 34 72-0000030-100
*10 80 MEDION*57F0 *10 80 MEDION*57F0
X (%OBLIG: %) X %OBLIG: %

*FIRST-NAME LAS *FIRST-NAME LAS
34 72-0000030-100 34 72-0000030-100
*10 80*POEON*57F0 *10 80*POEON*57F0
X %OBLIG: % X %OBLIG: %

*FIRST-NAME LAS *FIRST-NAME LAS
34 72-0000030-100 34 72-0000030-100
*10 80*POEON*57F0 *10 80*POEON*57F0
X %OBLIG: % X %OBLIG: %

*FIRST-NAME LAS *FIRST-NAME LAS
34 72-0000030-100 34 72-0000030-100
*10 80*POEON*57F0 *10 80*POEON*57F0
X %OBLIG: % X %OBLIG: %

MEDI-CAL BENEFICIARY — YOU MUST PRESENT THIS CARD TO YOUR PROVIDER WHEN YOU SEEK MEDICAL ATTENTION

DIALYSIS AID CODE 72

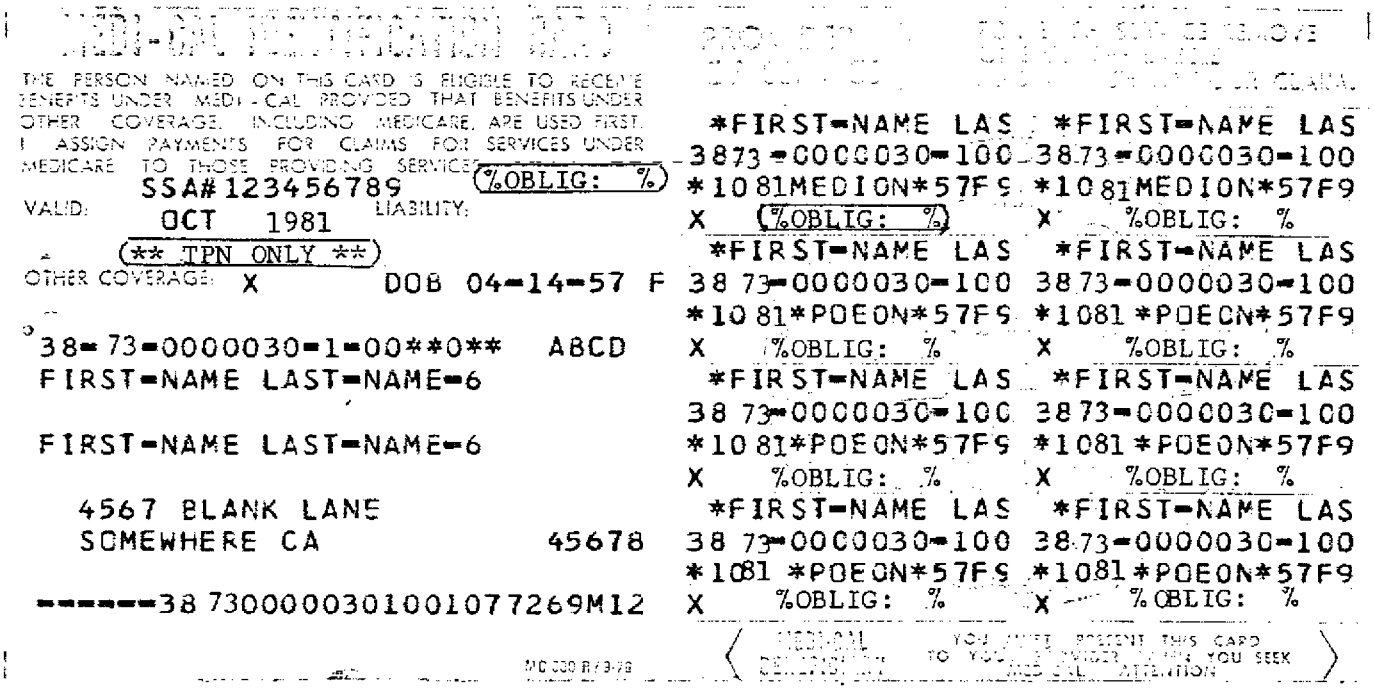
V. Medi-Cal Dialysis Supplement Identification Card Enclosure

"The attached Medi-Cal identification card identifies you as eligible to receive benefits under the Medi-Cal Dialysis Supplement program. This identification card is to be presented to your provider when you seek dialysis services including related hospital and physician services associated with the treatment of renal failure, stabilization of renal failure, treatment of complications of dialysis and dialysis related laboratory tests, medical supplies, and drugs. YOUR MEDI-CAL DIALYSIS SUPPLEMENT CARD MAY NOT BE USED FOR ROUTINE FULL-CARE DIALYSIS TREATMENT; NOR MAY IT BE USED FOR MEDICAL SERVICES WHICH ARE NOT RELATED TO DIALYSIS.

"Under the Medi-Cal Dialysis Supplement program you are obligated to pay a percentage of the costs of dialysis services not covered by other insurance or other government programs. Your percentage obligation is printed on your Medi-Cal card (%OBLIG:X%). Using this percentage your provider will compute the amount you must pay him for your dialysis services. For instance, if a dialysis service costs $1,000 and you have insurance or other coverage for $200, your percentage obligation would apply to the remaining $800. If your percentage obligation is 2 percent, then you must pay 2 percent of $800 or $16.00. The Medi-Cal program will then pay the remainder of reasonable charges."

TPN ONLY STATEMENT

PERCENTAGE OBLIGATION



TPN AID CODE 73

VI. Medi-Cal TPN Only Identification Card Enclosure

"The attached Medi-Cal identification card identifies you as eligible to receive benefits under the Medi-Cal TPN Only program. This identification card is to be presented to your provider when you require TPN services or supplies. MEDI-CAL WILL COVER ONLY INPATIENT HOSPITAL CARE DIRECTLY RELATED TO TPN INCLUDING HOME TPN TRAINING, HOME TPN AND RELATED SERVICES AND SUPPLIES.

"Under the Medi-Cal TPN Only program you are obligated to pay a percentage of the costs of TPN services not covered by other insurance or other government programs. Your percentage obligation is printed on your Medi-Cal card (%OBLIG:X%). Using this percentage your provider will compute the amount you must pay for your TPN services. For instance, if a TPN service costs $1,000 and you have insurance or other coverage for $200, your percentage obligation would apply to the remaining $800. If your percentage obligation is 2 percent, then you must pay 2 percent of $800 or $16.00. The Medi-Cal program will then pay the remainder of reasonable charges."

17C - MEDICARE ELIGIBILITY AND THE MEDI-CAL DIALYSIS SPECIAL TREATMENT PROGRAMS

I. Importance of Medicare for Dialysis Eligibles

Counties must closely monitor the Medicare eligibility of dialysis cases for the following reasons:

A. A Dialysis Only beneficiary who is under 65 loses Dialysis Only eligibility once Medicare eligibility is established.

B. Although Dialysis Supplement eligibility does not end when Medicare eligibility is established, Medicare takes over most of the dialysis costs from that point.

II. Medicare Eligibility Requirements for Dialysis Patients

To be eligible for the Medicare Dialysis program:

A. The individual must be fully or currently insured under Social Security or must be the spouse, dependent child, former spouse, widow, etc., of an insured individual. Fully insured individuals have 40 calendar quarters work credit under Social Security; currently insured individuals must have 6 calendar quarters out of the past 13 work credit with Social Security.

B. The individual must be suffering from chronic kidney failure.

C. The individual must apply with Social Security for Medicare benefits.

III. Waiting Period for Medicare Coverage

There is a three-month waiting period between onset of chronic kidney failure and the beginning of Medicare coverage. However, patients who are eligible for Medicare Dialysis may have their coverage begin as soon as their application is completely processed by Social Security as follows:

A. Individuals who enter self-care or home dialysis training at any time during the three-month waiting period will have the entire waiting period waived; their Medicare coverage begins with the first month of treatment for chronic kidney failure.

B. Medicare coverage is retroactive, for up to 12 months before application, if the person met the coverage criteria in the past months. So a person whose Medicare application is not approved until the fourth month after kidney failure sets in, would have coverage start at the time of approval.

IV. Monitoring Changes in Medicare Eligibility

A. Background Information

1. Medicare Application

Social Security district offices generally expedite the applications of persons in need of dialysis treatment. Staff usually are able to evaluate the information given and to inform the applicant whether it appears there will be eligibility for Medicare, either at the time of application or shortly thereafter. Under certain circumstances, however, Medicare eligibility determination becomes complex, and such a timely evaluation is not possible.

In most cases, Social Security will inform applicants whether or not they are eligible for Medicare within three months of application. If there has been no response received by the end of the third month, the applicant must check with Social Security.

2. Calendar Quarters of Work Credit

Upon request, Social Security will provide to individuals a statement of their quarters of work credit called "Quarters of Coverage". Social Security reports may understate quarters of coverage by up to one year (four quarters) for currently employed persons. An estimate of how many quarters of work credit are required before an employed person, or covered dependent, will become eligible for Medicare can be made by subtracting the number of existing quarters of coverage from the number of required quarters.

For example, a person with only 2 quarters of coverage will have to work in a job covered under Social Security for 1 additional year to become eligible; a person with no quarters would have to work for 18 months.

B. Client Responsibilities

1. Applicants must apply for Medicare coverage within ten days of making application for a special dialysis program, unless they provide a current Social Security statement of Medicare status. Failure to do so without good cause will result in denial of the application.

2. Special Dialysis program beneficiaries must provide the county with a copy of the Social Security statement of Medicare status, or any evidence of eligibility such as a card or letter, within ten days of receiving such evidence.

17D - MEDI-CAL DIALYSIS SUPPLEMENT SPECIAL TREATMENT PROGRAM: CLIENT INFORMATION

If you need kidney dialysis and qualify for the Medi-Cal Dialysis Supplement Special Treatment Program, that program could reduce your out-of-pocket dialysis costs. Here are key facts and rules about the program.

I. Dialysis Supplement Eligibility Requirements

You must be all of these things in a month:

- In need of dialysis.
- Eligible for regular Medi-Cal with a personal or family share of cost.
- Employed, or self-employed, with gross earnings which are greater than the individual Medi-Cal maintenance need for one person.
- Receiving either home dialysis or self-care clinic dialysis.

II. Information for Dialysis Supplement Eligibles

A. Advantages of Dialysis Supplement Program

This program provides you medical cost relief for dialysis and related services. Under the regular Medi-Cal program, you must pay all your surplus income toward meeting your share of cost for medical care. Under this program, you need pay only a percentage of the cost for dialysis services after any other health coverage payment is subtracted from the cost of those services.

B. Using Your Other Health Coverage

If you have Medicare, private health insurance, or any other non-Medi-Cal coverage, that coverage must be billed first for the cost of a dialysis service. Your percentage obligation applies to the balance remaining after payment by such other coverage. For example, if Medicare covers $80 of a $100 charge, your percentage obligation will be applied only to the remaining $20. The provider subtracts what you owe from the $20, and bills Medi-Cal for the rest.

C. What You Pay Toward the Cost of Your Dialysis Care

The amount you pay toward each dialysis service depends on the annual net worth of you and your spouse, or you and your parents if you are under 18. Annual net worth is annual income plus property holdings. The following are not counted as part of your property holdings:

The first $40,000 of your home's taxable value, one vehicle, $1,000 for burial expenses, burial plots or vaults, wedding and engagement rings, heirlooms, clothing, household furnishings, and household equipment.

If your annual net worth is less than $5,000, you pay nothing. If it is more than $5,000, you pay one percent of the net cost of each dialysis service for each $5,000 of annual net worth you have. For example, if your annual net worth is $15,000, you pay three percent of the net cost of each dialysis service. The percent you pay is called your "percentage obligation".

D. How Your Dialysis Supplement Eligibility Fits into Your Regular Medi-Cal Eligibility

Dialysis Supplement covers dialysis and related services only. If you or your family need other types of medical care, you must meet your regular Medi-Cal share of cost before you can receive a regular Medi-Cal card. The amount you pay for dialysis and related services as part of your Dialysis Supplement eligibility will be a credit against your share of cost, just the same as any other medical bill you pay. Be sure and have your dialysis provider or supplier fill out your "Record of Health Care Costs", form (MC 177). Once you receive a regular Medi-Cal card for any month, you must use it for all medical services, including dialysis, for the remainder of that month.

E. What Happens if You Lose Regular Medi-Cal Eligibility

Eligibility for Dialysis Supplement depends on eligibility for the regular Medi-Cal program. If you lose eligibility for regular Medi-Cal for any reason, including accumulation of excess resources, you will no longer be eligible for Dialysis Supplement. In this case, the county welfare department will determine your eligibility under the Dialysis Only program.

III. Services Covered by the Medi-Cal Dialysis Supplement Program

A. Dialysis Supplement Benefits

The Medi-Cal Dialysis Supplement program covers the full range of dialysis services except routine full-care dialysis. Routine full-care dialysis is not a Dialysis Supplement benefit. This exclusion does not preclude provision of full-care dialysis treatment in cases of a physician certified medical emergency. Dialysis Supplement coverage ends when you meet your regular Medi-Cal share of cost, since for the rest of the month you are entitled to free Medi-Cal services, including routine full-care dialysis.

B. Definition of Dialysis and Related Services

Dialysis and related services are defined in Title 22, California Administrative Code, Section 51157: "Renal Dialysis, Renal Homotransplantation, and Related Services" as follows:

"(a) 'Renal dialysis' means removal by artificial means of waste products normally excreted by the kidneys. Such removal may be accomplished by the use of an artificial kidney or peritoneal dialysis on a continuing basis.*

"(b) 'Renal homotransplantation' means the implantation of a kidney from one person to another for the treatment of renal disease.

"(c) 'Related services' means hospital inpatient and physician's services related to the treatment of renal failure, stabilization of renal failure, treatment of complications of dialysis, and dialysis related laboratory tests, medical supplies, and drugs."

*(Note: "Renal dialysis" means full-care, self-care, or home-care dialysis.)

C. Definitions of Types of Dialysis

1. Full-care dialysis is provided in a dialysis clinic or a hospital outpatient clinic. Treatment is fully managed by staff; the patient takes no part in managing his or her own care.

2. Self-care dialysis takes place in a "self-care dialysis unit" of a dialysis clinic or hospital outpatient clinic. The patient manages his or her own treatment with less staff supervision required.

3. Home dialysis takes place in the home. The patient has a home dialysis unit and dialyzes at home. Usually a dialysis clinic or outpatient hospital clinic will supervise the patient's home care and will provide needed supportive services, including the services of qualified home dialysis aides on a selective basis.

IV. Your Responsibilities

A. Medicare Application

1. You must apply for Medicare coverage within ten days of making application for this program unless you already have Medicare coverage or have a statement from Social Security showing you are currently not eligible for Medicare.

2. You must provide the county welfare department a copy of the Social Security Medicare status, or any evidence of eligibility such as a card or letter, within ten days of receipt.

3. If you are not currently eligible for Medicare, you must request a statement of quarters of coverage from Social Security (Social Security Benefit Estimate Form). You should determine, with the aid of a Social Security representative, how many more quarters of coverage you need to become eligible for Medicare. This information must be given to the county welfare department or your eligibility will have to be redetermined every quarter. It is to your direct advantage to apply for Medicare as soon as you believe you are eligible. The cost you must pay is based on the balance left after Medicare or any other insurance has paid. Medicare coverage can reduce your cost up to 80 percent.

B. General Reporting Responsibilities

You must report any change in status that could affect your dialysis program eligibility or your percentage obligation. These include, but are not limited to:

- Loss of employment.

- Change in marital status.

- Increase/decrease in earnings.
- Change in other health coverage.

I have reviewed the above information with the county representative. I understand my responsibilities in regard to Medicare and general reporting requirements.

_____ _____
Applicant Date

I have explained the Medi-Cal Dialysis Supplement requirements listed above to the applicant.

_____ _____
County Representative Date

17E - MEDI-CAL TPN SUPPLEMENT SPECIAL TREATMENT PROGRAM: CLIENT INFORMATION

If you require parenteral hyperalimentation treatment, also known as total parenteral nutrition (TPN), and qualify for the Medi-Cal TPN Supplement program, that program could reduce your out-of-pocket TPN costs. Here are key facts and rules about the program.

I. TPN Supplement Eligibility Requirements

You must be all of these things in a month:

- In need of TPN.
- Performing home TPN treatment.
- Eligible for regular Medi-Cal with a personal or family share of cost.
- Employed, or self-employed, with gross monthly earnings which are greater than the individual Medi-Cal maintenance need for one person.

II. Information for TPN Supplement Eligibles

A. Advantages of TPN Supplement Program

This program provides you medical cost relief for home TPN treatment. Under the regular Medi-Cal program, you must pay all your surplus income toward meeting your share of cost for medical care. Under this program, you need pay only a percentage of the cost for home TPN treatment after any other health coverage payment is subtracted from the cost of those services.

B. Using Your Other Health Coverage

If you have Medicare, private health insurance, or any other non-Medi-Cal coverage, that coverage must be utilized or billed first for the cost of home TPN treatment. Your percentage obligation applies to the balance remaining after payment by such other coverage. For example, if Medicare covers $80 of a $100 charge, your percentage obligation will be applied only to the remaining $20. The provider subtracts what you owe from the $20 and bills Medi-Cal for the rest.

C. What You Pay Toward the Cost of Your Home TPN Treatment

The amount you pay toward your home TPN treatment depends on the annual net worth of you and your spouse, or you and your parents if you are under 18. Annual net worth is annual income plus property holdings. The following are not counted as part of your property holdings:

The first $40,000 of your home's taxable value, one vehicle, $1,000 for burial expenses, burial plots or vaults, wedding and engagement rings, heirlooms, clothing, household furnishings, and household equipment.

If your annual net worth is less than $5,000, you pay nothing. If it is $5,000 or more, you pay one percent of the net cost of your home TPN treatment costs for each $5,000 of annual net worth you have. For example, if your annual net worth is $15,000, you pay three percent of the net costs of your home TPN treatment costs. The percent you pay is called your "percentage obligation".

D. How Your TPN Supplement Eligibility Fits into Your Regular Medi-Cal Eligibility

TPN Supplement covers home TPN supplies and related services only. If you or your family need other types of medical care, you must meet your regular Medi-Cal share of cost before you can receive a regular Medi-Cal card. The amount you pay for home TPN supplies and related services as part of your TPN Supplement eligibility will also be a credit against your share of cost, just the same as any other medical bill you pay. Be sure and have your medical provider or supplier fill out your "Record of Health Care Costs", form MC 177. Once you receive a regular Medi-Cal card for any month, you must use it for all medical services, including TPN, for the remainder of that month.

E. What Happens if You Lose Regular Medi-Cal Eligibility

Eligibility for TPN Supplement depends on eligibility for the regular Medi-Cal program. If you lose eligibility for regular Medi-Cal for any reason, including accumulation of excess resources, you will no longer be eligible for TPN Supplement. In this case, the county welfare department will determine whether you are eligible under the TPN Only program.

III. Services Covered by the Medi-Cal TPN Supplement Special Treatment Program

A. TPN Supplement Benefits

The TPN Supplement Special Treatment Program covers only a limited range of outpatient benefits. You may use your TPN Supplement Medi-Cal card for approved nutrient solutions and related supplies, related laboratory services, and outpatient physician visits.

If you require treatment for an underlying condition, acute hospital care, or other forms of medical care, you must meet your regular Medi-Cal share of cost before Medi-Cal will pay for these services.

IV. Your Responsibilities

A. Medicare Application

You must apply for Medicare coverage after you apply for this program if you are receiving Social Security Title II Disability benefits.

You must provide the county welfare department with a copy of the Social Security Medicare status statement, or any evidence of eligibility such as a card or letter, within 60 days of your Medicare application. If Social Security does not provide you with a Medicare status statement within 60 days, you must provide a copy to the county welfare department as soon as you do receive it.

B. General Reporting Responsibilities

You must report any change in status that could affect your TPN Supplement Special Treatment Program eligibility or your percentage obligation. Such changes include, but are not limited to:

- Loss of employment.
- Change in marital status.
- Increase/decrease in earnings.
- Change in other health coverage.

I have reviewed the above information with the county representative. I understand my responsibilities in regard to Medicare and general reporting requirements.

_____ _____

Applicant Date

I have explained the Medi-Cal TPN Supplement requirements listed above to the applicant.

_____ _____

County Representative Date

Health and Welfare Agency
Medi-Cal Program

Department of Health S

MEDI-CAL SPECIAL TREATMENT PROGRAMS -- PERCENTAGE OBLIGATION COMPUTATION

CO. DIST.	COUNTY

PART I Identification — Special Treatment Program Applicant

ame (First) (Middle) (Last)

Address

City State Zip Code

(B) MN/MI Medi-Cal Case Name

(D) Date of Eligibility
Month Year

(E) Redetermination Date
Month Year

(F) Percentage Obligation

(G) Program

(C) MN/MI Medi-Cal ID Number					Medi-Cal Special Treatment Program ID Number					Birthdate	Sex	Other Cov. Code	(1) Social Security Number
Co.	Aid	7 Digit Serial No.	FBU	Pers	Co.	Aid	7 Digit Serial No.	FBU	Pers	Mo. Day Yr.			(2) HIC or RR Number

PART II ELIGIBILITY REQUIREMENTS — SUMMARY

SPECIAL TREATMENT — ONLY, PROGRAMS

Percentage Obligation Rate — 2% per $5,000 Annual Net Worth

Dialysis Only — Aid Code 71 / TPN Only — Aid Code 73

The Applicant Must Meet All Of The Following:

1. Needs dialysis or TPN and related services.
2. Not eligible for Medi-Cal under any other program due to excess resources.
3. Meets Medi-Cal requirements of citizenship/alienage, residence, institutional status, and cooperation.
4. Not eligible for Medicare, or Medicare pending, if under age 65.

SPECIAL TREATMENT — SUPPLEMENT, PROGRAMS

Percentage Obligation Rate — 1% per $5,000 Annual Net Worth

Dialysis Supplement — Aid Code 72 / TPN Supplement Aid Code 74

The Applicant Must Meet All Of The Following:

1. Needs dialysis or TPN and related services.
2. Approved as MN or MI with a share of cost.
3. Employed or self-employed.
4. Earns an individual gross income in excess of the (regular) one-person maintenance need.

PART III ANNUAL NET WORTH COMPUTATIONS

A REAL PROPERTY

Property used as a home:

(a) Full market value $
(b) Exempted value −40,000
(c) Pro rata encumbrances $
(d) Excess market value $

2. Property not used as a home:

(a) Full market value $
(b) Encumbrances −
(c) Net market value $

B PERSONAL PROPERTY

3. Liquid Assets — Itemize:

Total $

4. Other — Itemize

Total $

C INCOME

5. Gross earned income for 12 months $
6. Gross unearned income for 12 months $
7. Total gross income (add lines 5 and 6) $
8. Allowable adjustment deductions (per federal tax law) $
9. Total adjusted gross income $

D PERCENTAGE OBLIGATION DETERMINATION

10. Annual Net Worth (round down to nearest multiple of $5,000) $
11. Percentage obligation computation (line 10 divided by $5,000)
12. Percentage obligation rate
13. Percentage obligation — Enter in Block F above (line 11 multiplied by line 12)

☐ Send cards to county ☐ Send cards to beneficia

Eligibility Worker's Signature Date

Comments:
Medi-Cal Special Treatment Program cards requested for:

Signature of Verifier

INSTRUCTIONS
MEDI-CAL SPECIAL TREATMENT PROGRAMS - PERCENTAGE OBLIGATION COMPUTATION
FORM MC 176-D
(1/81)

Form MC 176-D, Medi-Cal Special Treatment Programs - Percentage Obligation Computation, is to be used to determine eligibility and compute the percentage obligation for all applicants for any of the Medi-Cal Special Treatment Programs. This form is completed at the time of a new application, restoration, reapplication, change in net worth affecting percentage obligation, and redetermination. The applicant must also complete an MC 210, Statement of Facts for Medi-Cal, at the time of initial application and at annual redetermination.

The original of the completed form MC 176-D is to be sent to:

Department of Health Services
Benefits Review Unit
Att: Medi-Cal Special Programs
Coordinator
P. O. Box 668
Sacramento, CA 95803

I. How to Complete Form

Part I -- Identification

Block A (Name and Address): Complete for all clients.

Block B (MN/MI Case Name): Complete for Supplement clients.

Block C (Medi-Cal ID Numbers, Birth Date, etc.):

- Enter MN/MI Medi-Cal beneficiary ID numbers for "Supplement" clients. (This additional information is used by the State to claim federal funds for Special Treatment Programs -- Supplement eligibles who have met their MN/MI share of cost.)

- Enter Medi-Cal Special Treatment Program beneficiary ID number for all clients.

- For all clients, enter birth date, sex, other coverage code, and HIC number or RR number if Medicare coverage is established. If applicant is not currently eligible for Medicare, a new MC 176-D must be sent to Benefits Review Unit (BRU) when notification of Medicare coverage is received.

  Note: Medicare eligibility is not a factor in Special Treatment Programs -- Supplement eligibility.

Block D (Date of Eligibility): First month to which this percentage obligation applies. This is the month of initial eligibility or effective month of most recent reevaluation or redetermination.

Block E (Redetermination Date): Date of next annual redetermination. Reevaluation of eligibility will occur before than, when clients advise of changes in circumstances, Medicare eligibility, or submit status reports.

Note: Medicare eligibility will disqualify any individual who is under 65 from Medi-Cal Special Treatment Programs -- Only coverage.

Block F (Percentage Obligation): Enter client percentage obligation from Part III.D, line 13. This percentage will be printed on the Medi-Cal card and on each label.

Block G (Program): Indicate program category for which applicant requests coverage in Part I (G); i.e., TPN Only, Dialysis Supplement, etc. Be sure the Medi-Cal aid code corresponds to this category. Special Treatment Program cards limit the user to certain specified services.

Part II -- Special Treatment Programs Eligibility Requirements - Summary

See California Administrative Code (CAC), Title 22, Section 50817, for detailed explanation of eligibility requirements.

Part III -- Annual Net Worth Computations

A. Real Property

Real property means property used as a home as well as that other real property identified in CAC, Title 22, Sections 50427 through 50437.

1. Property Used as a Home

a. Full market value is the full value amount shown on the most recent tax assessment.

b. Exempted value is $40,000. This amount is subtracted from the full market value.

c. Pro rata encumbrances is that portion of the encumbrance which applies to the part of the home's value above the $40,000 exemption. The general formula is:

$$\text{Pro rata encumbrance} = \frac{\text{nonexempt market value}}{\text{market value}} \times \text{total encumbrance}$$

Example:

Full market value: $120,000

Encumbrance (mortgage, etc.): $90,000

Nonexempt value: $120,000 - $40,000 = $80,000

Pro rata encumbrance: $\frac{\$80,000}{\$120,000}$ = 2/3 x $90,000 = $60,000

The pro rata encumbrance is $60,000.

The calculation in Part A would be shown as follows:

A REAL PROPERTY	
1. Property used as a home:	
(a) Full market value	$ 120 000
(b) Exempted value	-40,000
(c) Pro rata encumbrances	$ -60,000
(d) Excess market value	$ 20,000

2. Other Real Property

Determine total full market value of all other real property, less total encumbrances, to find net market value. (See below.)

2. Property not used as a home:	
(a) Full market value	$
(b) Encumbrances	-
(c) Net market value	$

B. Personal Property

All property, except that excluded in CAC, Title 22, Section 50825 (e), shall be counted in determining net worth. However, any existing encumbrance shall be subtracted from the value of personal property.

C. Income

Total annual adjusted gross income is:

1. The adjusted gross income shown on the most recent federal income tax return; or

2. The projected adjusted gross income for the current year, allowing pertinent federal adjustments, providing current income is significantly lesser or greater than income in the preceding year.

D. Percentage Obligation Determination

1. Annual net worth is the total of countable real and personal property plus adjusted gross income. Round the total down to the nearest multiple of $5,000 (i.e., $5,995 is rounded down to $5,000).

2. Percentage obligation is found by dividing the rounded annual net worth (line 10) by $5,000. Beneficiaries with less than $5,000 of net worth will have a "zero percentage obligation".

3. Percentage obligation rate is the rate identified under the program headings. The Special Treatment Programs -- Only rate is two percent; the Supplement rate is one percent.

4. Multiply line 11 by the correct rate. Enter this answer in Part I, block (F).

Examples: Special Treatment Programs — All

Family annual net worth is $4,950. This amount is less than $5,000. The percentage obligation will be zero.

Special Treatment Programs -- Only

Family annual net worth is $78,000. Round down to the nearest multiple of $5,000. There are 15 units of $5,000 in $75,000. The percentage obligation will be 15 x 2 percent or 30 percent.

Special Treatment Programs -- Supplement

Family annual net worth is $18,500. Round down to the nearest multiple of $5,000. There are three $5,000 units in $15,000. The percentage obligation rate will be 3 x 1 percent or 3 percent.

II. Miscellaneous Instructions

A. New Cases

Send the original MC 176-D to BRU. Retain copies of all pertinent documents in the case file.

B. Continuing Cases, Redetermination Changes, Discontinuances, etc.

1. Use the comments space at the bottom of the MC 176-D to indicate what action was taken:

   - o Medicare eligibility established effective (date).
   - o Ineligible for Medicare, denial notice attached.
   - o Discontinued from (program) effective (date) due to (reason).

   (BRU will automatically issue Medi-Cal Special Treatment Program cards until the redetermination date, unless the county notifies them to stop.)

   Note: If Supplement beneficiaries become ineligible as an MN or MI, they also lose eligibility for that particular Medi-Cal Special Treatment Programs -- Supplement. Eligibility must then be determined under Special Treatment Programs -- Only.

2. Send the original of the revised MC 176-D to BRU.

MEDI-CAL SPECIAL TREATMENT PROGRAMS

NOTICE OF ACTION

State No.:
District:

We have reviewed all information available to us about your circumstances, and we find that:

☐ You are eligible for the Medi-Cal _____ Special Treatment Program beginning the first day of _____. Your percentage obligation rate is _____ percent per $5,000 of annual net worth. Your annual net worth was determined to be $_____ for the twelve month period from _____ through _____.

☐ Your percentage obligation is _____ %. This means that the person or organization providing you with supplies and services will send a bill for that cost to your insurance company, or to any other agency that provides you with coverage for these supplies and services. You will pay or obligate _____ % of the cost *NOT* paid by the insurance company or other agency. If you have no insurance or other coverage, you will pay or obligate _____% of the entire cost of the services. The costs not paid by your insurance or other coverage, or paid or obligated by you, will be paid by Medi-Cal.

☐ You must provide a copy by _____ of your notice of Medicare status from the Social Security Administration showing whether or not you are eligible for Medicare. If you fail to provide this notification, or provide information on why you are unable to do so, your Dialysis Special Treatment Program benefits will be discontinued.

☐ You are not eligible/Your eligibility has been discontinued for the Medi-Cal _____ Special Treatment Program effective the last day of _____ because:

The reason for this denial/discontinuance is:

The regulations which require this action are California Administrative Code Title 22, Section(s)

You are responsible for notifying the county welfare department within 10 days of any changes in income, property, or other circumstances. If you have other medical coverage, it must be used before Medi-Cal. Failure to tell the county welfare department about other health care coverage or failure to use other coverage available to you is a misdemeanor.

If you have any questions about this action or if there are additional facts relating to your circumstances which you have not reported to us, please write or telephone. We will answer your questions or make an appointment to see you in person.

_____ (Eligibility Worker) _____ (Phone Number) _____ (Dated)

PLEASE READ THE REVERSE SIDE OF THIS NOTICE